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Summary of Selected Provisions of the Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Proposed Rule for Calendar Year 2015

On July 3, 2014, the Centers for Medicare & Medicaid Services (CMS) released the hospital outpatient prospective payment system (OPPS) and ambulatory surgical center (ASC) payment system proposed rule for calendar year (CY) 2015 (the "Proposed Rule"). It was published in the Federal Register on July 14, 2014,[1] and CMS will accept comments on it until September 2, 2014.

CMS announced that the payment rates for 2015 will increase by 2.1 percent. This reflects a 2.7 percent increase in the hospital operating market basket, a -0.4 percent multifactor productivity (MFP) adjustment, and a 0.2 percentage point reduction required by the Affordable Care Act (ACA). Hospitals that fail to meet the quality data reporting requirements will receive an update that is reduced by 2.0 percentage points. CMS expects that total Medicare payments to hospital outpatient departments (HOPDs) will be approximately $56.5 billion and that total payments to ASCs will be $4.086 billion in 2015.

The addenda containing relative weights, payment rates, wage indices, and other payment information are available only on the CMS web site. Addenda relating to the OPPS are available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html. Addenda relating to the ASC payment system are available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html.

1. Cost-to-Charge Ratios (CCRs) and Cost Centers

CMS proposes to continue for CY 2015 to calculate the OPPS relative payment weights using distinct CCRs for cardiac catheterization, computed tomography (CT) scans, and magnetic resonance imaging (MRI). CMS also proposes to continue to use a distinct CCR for implantable medical devices.

CMS proposes to continue its policy finalized in the CY 2014 OPPS final rule with comment period to remove claims from providers that use a cost allocation method of "square feet" to calculate CCRs used to estimate costs associated with the CT and MRI ambulatory payment classifications (APCs). The policy will sunset in 4 years, once the updated cost report data become available for ratesetting purposes.

[1] CMS, Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Physician-Owned Hospitals: Data Sources for Expansion Exception; Physician Certification of Inpatient Hospital Services; Medicare Advantage Organizations and Part D Sponsors: Appeals Process for Overpayments Associated with Submitted Data; Proposed Rule, CMS-1613-P, 79 Fed. Reg. 40915 (July 14, 2014), *available at*: http://www.gpo.gov/fdsys/pkg/FR-2014-07-14/pdf/2014-15939.pdf.

Percentage Change in Estimated Cost for CT and MRI APCs when Excluding Claims from Providers Using "Square Feet" as the Cost Allocation Method

Proposed CY 2015 APC	Proposed CY 2015 APC Descriptor	Percentage Change
0283	Computed Tomography with Contrast	9.3%
0284	Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contrast	4.2%
0331	Combined Abdomen and Pelvis CT without Contrast	12.0%
0332	Computed Tomography without Contrast	14.1%
0333	Computed Tomography without Contrast followed by Contrast	12.1%
0334	Combined Abdomen and Pelvis CT with Contrast	10.1%
0336	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast	7.4%
0337	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast followed by Contrast	6.0%
0383	Cardiac Computed Tomographic Imaging	4.3%
0662	CT Angiography	10.3%
8005	CT and CTA without Contrast Composite	12.7%
8006	CT and CTA with Contrast Composite	9.2%
8007	MRI and MRA without Contrast Composite	6.3%
8008	MRI and MRA with Contrast Composite	6.3%

2. Establishment of Comprehensive APCs (C-APCs)

In the CY 2014 OPPS final rule, CMS finalized a policy with a delayed implementation date of CY 2015 under which certain covered outpatient services would be designated as "primary services" and assigned to C-APCs. For CY 2015, CMS proposes to continue to define the services assigned to C-APCs as primary services and to define a comprehensive service as a classification for the provision of a primary service and all adjunctive services and supplies provided to support the delivery of the primary service. The C-APC payment bundle would include all hospital services reported on a claim that typically are covered under Medicare Part B, with the exception of excluded services or services requiring separate payment by statute, such as mammography services and ambulance services; brachytherapy seeds; pass-through drugs, biologicals, and devices; recurring therapy services; certain preventative services; and self-administered drugs that are not otherwise packaged as supplies. The use of C-APCs would result in a single prospective Medicare payment and a single beneficiary copayment under the OPPS for the comprehensive service based on all included charges on the claim.

As part of the C-APC, CMS proposes to include services that are typically integral, ancillary, supportive, dependent, or adjunctive to the primary service, provided during the delivery of comprehensive service. Such services include diagnostic procedures; laboratory tests and other diagnostic tests and treatments that assist in the delivery of the primary procedure; visits and evaluations performed in association with the procedure; uncoded services and supplies used during the service; outpatient department services that are similar to therapy and delivery either by therapists or non-therapists as part of the comprehensive service; durable medical equipment (DME) as well as prosthetic and orthotic items and supplies when provided as part of the outpatient service; and any other components reported by Healthcare Common Procedure Coding System (HCPCS)

codes that are provided during the comprehensive services, with the exception of excluded services or services requiring separate payment by statute. Drugs, biologicals, and radiopharmaceuticals also are packaged for payment provided in conjunction with the primary service, with the exception of drugs with pass-through payment status and those that are usually self-administered, unless they function as packaged supplies.

For CY 2015, CMS proposes a C-APC payment methodology that adheres to the same basic principles as those finalized in the CY 2014 OPPS final rule with comment period with the following proposed changes for CY 2015:

(1) Reorganization and consolidation of several of the current device-dependent APCs and CY 2015 C-APCs

As described below, CMS proposes to consolidate some of the current device-dependent APCs to improve both the resource and clinical homogeneity of these APCs.

- *Endovascular procedures*: CMS proposes to combine C-APCs 0082, 0083, 0104, 0229, 0319, and 0656 to form three proposed levels of comprehensive endovascular APCs.
- *Automatic Implantable Cardiac Debrillators, Pacemakers, and Related Devices*: CMS proposes to combine C-APCs 0089, 0090, 0106, 0654, 0655, and 0680 to form three proposed levels of C-APCs within a broader series of APCs for pacemaker implantation and similar procedures.
- *Event Monitoring:* CMS proposes to delete the clinical family for Event Monitoring, which had only one C-APC with a single Current Procedural Terminology (CPT®)[2] code 33282. CPT code 33282 will be reassigned to C-APC 0090.
- *Urogenital procedures:* CMS proposes two levels instead of three levels for these procedures and to reassign several codes from APC 0195 to C-APC 0202 (Level V Female Reproductive Procedures).
- *Arthroplasty procedures:* CMS proposes to rename the arthroplasty family of APCs to Orthopedic Surgery and proposes to reassign several codes from APC 0052 to C-APC 0425, which will be renamed "Level V Musculoskeletal Procedures Except Hand and Foot."
- *Electrophysiologic Procedures:* CMS proposes three levels of electrophysiologic procedures and renaming APC 0086 "Level III Electrophysiologic Procedures." CMS also is proposing to replace composite APC 8000 with proposed C-APC 0086.
- *New clinical families:* CMS proposes three new clinical families: Gastrointestinal Procedures (GIXXX) for gastrointestinal stents, Tube/Catheter Changes (CATHX) for insertion of various catheters, and Radiation Oncology (RADTX), which would include C-APC 0067.

(2) Expansion of the C-APC policy to include all device-dependent APCs and to create two other new C-APCs (C-APC 0067 and C-APC 0351)

CMS proposes to convert all current device-dependent APCs remaining after the proposed restructuring and consolidation of some of these APCs to C-APCs. CMS is also proposing two new C-APCs: C-APC 0067 for single-session cranial stereotactic radiosurgery (SRS) and C-APC 0351

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for intraocular telescope implantation. CMS also is proposing to reassign CPT codes 77424 and 77425 that describe intraoperative radiation therapy treatment (IORT) to C-APC 0648 (Level IV Breast and Skin Surgery).

(3) Declining to apply the C-APC concept to stem cell transplants

CMS declined a commenter's request to apply the C-APC concept to outpatient stem cell transplants. Instead, the agency proposed to continue to pay separately for allogeneic transplantation procedures under APC 0111 (Blood Product Exchange) and APC 0112 (Apheresis and Stem Cell Procedures) with proposed rule geometric mean costs of approximately $1,127 and $3,064 respectively. Hospitals should report all allogeneic outpatient stem cell transplant acquisition charges on the recipient's outpatient claim as uncoded charges under revenue code 0819. CMS noted that converting the stem cell transplant APCs to C-APCs only would provide a modest increase in payment and that the agency would continue to examine the costs associated with this service and how they could best be captured for payment ratesetting purposes in the OPPS in the future.

(4) New Complexity Adjustment Criteria

CMS proposes to adjust C-APC assignments for complexity by assigning claims with certain combinations of services to a higher paying C-APC in the same clinical family. For CY 2015, CMS proposes to modify the complexity adjustment criteria finalized in CY 2014 by lowering the volume and cost threshold criteria for these combinations of services. The new complexity adjustment criteria will require a frequency of 25 or more claims reporting the HCPCS code combination and violation of the "2 times" rule. CMS proposes to use the complexity adjustments to provide increased payment for certain comprehensive services.

(5) Packaging of all add-on codes

In the CY 2014 OPPS final rule, CMS proposed to assign some add-on codes a status indicator ("J1") that would identify them as a primary service. Instead, for CY 2015, CMS proposes to package all add-on codes furnished as part of a comprehensive service, consistent with the add-on code packaging policy. However, the add-on codes assigned to the device-dependent APCs would be evaluated with a primary service for a potential complexity adjustment.

CMS proposes to continue to define a clinical family of C-APCs as a set of clinically related C-APCs that represent different resource levels of clinically comparable services. CMS proposes a total of 28 C-APCs within 13 clinical families for CY 2015, as shown in the table below.

Clinical Family	**Proposed CY 2015 C-APC**	**APC Title**	**Proposed CY 2015 APC Geometric Mean Cost**
Automatic Implantable Cardiac Defibrillators, Pacemakers, and Related Devices (AICDP)	0090	Level II Pacemaker and Similar Procedures	$6,961.45
AICDP	0089	Level III Pacemaker and Similar Procedures	$9,923.94

AICDP	0655	Level IV Pacemaker and Similar Procedures	$17,313.08
AICDP	0107	Level I ICD and Similar Procedures	$24,167.80
AICDP	0108	Level II ICD and Similar Procedures	$32,085.90
Breast Surgery	0648	Level IV Breast and Skin Surgery	$7,674.20
Tube/ Catheter Changes (CATHX)	0427	Level II Tube or Catheter Changes or Repositioning	$1,522.15
CATHX	0652	Insertion of Intraperitoneal and Pleural Catheters	$2,764.85
ENT Procedures	0259	Level VII ENT Procedures	$31,273.34
Cardiac Electrophysiology (EPHYS)	0084	Level I Electrophysiologic Procedures	$922.84
EPHYS	0085	Level II Electrophysiologic Procedures	$4,807.69
EPHYS	0086	Level III Electrophysiologic Procedures	$14,835.04
Ophthalmic Surgery (EYEXX)	0293	Level IV Intraocular Procedures	$9,049.66
EYEXX	0351	Level V Intraocular Procedures	$21,056.40
Gastrointestinal Procedures	0384	GI Procedures with Stents	$3,307.90
Neurostimulators (NSTIM)	0061	Level II Neurostimulator & Related Procedures	$5,582.10
NSTIM	0039	Level III Neurostimulator & Related Procedures	$17,697.46
NSTIM	0318	Level IV Neurostimulator & Related Procedures	$27,283.10
Orthopedic Surgery	0425	Level V Musculoskeletal Procedures Except Hand and Food	$10,846.49
Implantable Drug Delivery Systems	0227	Implantation of Drug Infusion Device	$16,419.95
Radiation Oncology	0067	Single Session Cranial Stereotactic Radiosurgery	$10,227.12
Urogenital Procedures (UROGN)	0202	Level V Female Reproductive Procedures	$4,571.06
UROGN	0385	Level I Urogenital Procedures	$8,019.38
UROGN	0386	Level II Urogenital Procedures	$14,549.04
Vascular Procedures (VASCX)	0083	Level I Endovascular Procedures	$4,537.95
VASCX	0229	Level II Endovascular Procedures	$9,997.53
VASCX	0319	Level III Endovascular Procedures	$15,452.77
VASCX	0622	Level II Vascular Access Procedures	$2,635.35

3. Device-Dependent APCs

Historically, device-dependent APCs are populated by HCPCS codes that usually, but not always, require that a device be implanted or used to perform the procedure. In the CY 2014 OPPS final rule with comment period, CMS finalized a policy to create 29 C-APCs for 29 device-dependent services, where the cost of the device is large compared to other costs that contribute to the cost of delivering the primary service. CMS delayed implementation of this policy until CY 2015.

The proposed CY 2015 C-APC policy consolidates and restructures the 39 current device-dependent APCs into 26 of the total 28 C-APCs. Device-dependent APCs no longer will exist if this policy is implemented because these APCs all will have been converted to C-APCs.

For CY 2014, CMS proposed but did not finalize a policy to reduce the burden on hospitals and the Medicare program by no longer implementing procedure-to-device edits and device-to-procedure edits for any APCs. CMS proposes to implement this policy for CY 2015 because the agency believes that hospitals now have more experience in coding and reporting these claims fully and, for the most costly devices, the C-APCs will reliably reflect the cost of the device if it is included anywhere on the claim. Although hospitals still would be expected to adhere to the guidelines of correct coding and append the correct device code to the claim when applicable, claims no longer would be returned to providers when specific procedure and device code pairings do not appear on a claim.

In response to stakeholder concerns about the costs of devices being reported and captured, however, CMS also is proposing to create claims processing edits that require any of the device codes used in the previous device-to-procedure edits to be present on the claim whenever a procedure code assigned to any 1 of the 26 proposed C-APCs shown in the table below is reported on the claim.

Proposed APCs That Would Require a Device Code to Be Reported on a Claim When a Procedure Assigned to One of These APCs is Reported	
APC	**APC Title**
0039	Level III Neurostimulator
0061	Level II Neurostimulator
0083	Level I Endovascular
0084	Level I Electrophysiologic Procedures
0085	Level II Electrophysiologic Procedures
0086	Level III Electrophysiologic Procedures
0089	Level III Pacemaker
0090	Level II Pacemaker
0107	Level I Implantation of Cardioverter-Defibrillators (ICDs)
0108	Level II Implantation of Cardioverter-Defibrillators (ICDs)
0202	Level V Female Reproductive
0227	Implantation of Drug Infusion
0229	Level II Endovascular
0259	Level VII ENT Procedures
0293	Level IV Intraocular
0318	Level IV Neurostimulator

Proposed APCs That Would Require a Device Code to Be Reported on a Claim When a Procedure Assigned to One of These APCs is Reported	
APC	**APC Title**
0319	Level III Endovascular
0384	GI Procedures with Stents
0385	Level I Urogenital
0386	Level II Urogenital
0425	Level V Musculoskeletal
0427	Level II Tube/Catheter
0622	Level II Vascular Access
0648	Level IV Breast Surgery
0652	Insertion of Intraperitoneal/Pleural Catheters
0655	Level IV Pacemaker

4. Proposed Changes to Packaged Items and Services

CMS reiterates its view that the OPPS packages payment for multiple interrelated items and services into a single payment to encourage hospitals to furnish services efficiently and to negotiate effectively with manufacturers and suppliers to reduce the purchase price of items and services or explore alternative group purchasing arrangements. CMS also believes that packaging payments promotes the predictability and accuracy of payment for services over time and may reduce the importance of refining service-specific payment.

As part of its effort to make OPPS payments for all services paid under the OPPS more consistent with those of a prospective payment system and less like those of a per service fee schedule, CMS examined the HCPCS code definitions to determine whether there were categories of codes for which packaging would be appropriate according to existing OPPS packaging policies or a logical expansion of those existing OPPS packaging policies. CMS proposes for CY 2015 to package the costs of selected HCPCS codes into payment for services reported with other HCPCS codes where CMS believes that one code reported an item or service that was integral, ancillary, supportive, dependent, or adjunctive to the provision of care that was reported by another HCPCS code.

a. Proposed Revisions of a Packaging Policy Established in CY 2014 – Procedures Described by Add-On Codes

In the CY 2014 OPPS final rule, CMS packaged add-on codes in the OPPS, with the exception of add-on codes describing drug administration. As described above, CMS also adopted a C-APC policy for which implementation would be delayed until CY 2015. Under the policy, CMS would continue to pay separately for only those add-on codes (except for drug administration add-on codes) that were assigned to device-dependent APCs in CY 2014, but that, after CY 2014, these device-dependent add-on codes would be paid under the C-APC policy. CMS proposes instead to package all of the procedures described by add-on codes that are currently assigned to device-dependent APCs, which will be replaced by C-APCs. The device-dependent add-on codes that are separately paid in CY 2014 that CMS proposes to package in CY 2015 are listed in the table below.

Add-on Codes Assigned to Device-Dependent APCs for CY 2014 That are Proposed to Be Packaged in CY 2015		
CY 2014 Add-on Code	Short Descriptor	CY 2014 APC
19297	Place breast cath for rad	0648
33225	L ventric pacing lead add-on	0655
37222	Iliac revasc add-on	0083
37223	Iliac revasc w/stent add-on	0083
37232	Tib/per revasc add-on	0083
37233	Tib/per revasc w/ather add-on	0229
37234	Revsc opn/prq tib/pero stent	0083
37235	Tib/per revasc stnt & ather	0083
37237	Open/perq place stent ea add	0083
37239	Open/perq place stent ea add	0083
49435	Insert subq exten to ip cath	0427
92921	Prq cardiac angio addl art	0083
92925	Prq card angio/athrect addl	0082
92929	Prq card stent w/angio addl	0104
92934	Prq card stent/ath/angio	0104
92938	Prq card revasc byp graft addl	0104
92944	Prq card revasc chronic addl	0104
92998	Pul art balloon repr precut	0083
C9601	Perc drug-el cor stent bran	0656
C9603	Perc d-e cor stent ather br	0656
C9605	Perc d-e cor revasc t cabg b	0656
C9608	Perc d-e cor revasc chro add	0656

b. Proposed Packaging Policies for CY 2015

(i) Ancillary Services

Under the OPPS, CMS pays separately for certain ancillary services. In the CY 2014 OPPS final rule, CMS stated that ancillary services should be packaged when they are performed with another service but should continue to be paid separately when performed alone. However, CMS did not finalize the ancillary packaging policy proposed for CY 2014 because CMS believed that further evaluation was needed.

For CY 2015, CMS proposes to conditionally package certain ancillary services for CY 2015. CMS proposes to limit the initial set of APCs that contain conditionally packaged services to those ancillary service APCs with a proposed geometric mean cost of less than or equal to $100 (prior to application of the conditional packaging status indicator).

CMS proposes to limit the initial set of packaged ancillary service APCs as a result of concerns expressed in public comments that certain low volume but relatively costly ancillary services would have been packaged into high volume but relatively inexpensive primary services. CMS notes that this limit is not intended as a threshold above which ancillary services will not be packaged but rather is intended to be used as the methodology for selecting the initial set of conditionally

packaged ancillary service APCs under the proposed packaging policy. CMS may in the future package ancillary services assigned to APCs with geometric mean costs higher than $100 and adds that a change in the geometric mean cost of any of the proposed APCs above $100 would not change the conditionally packaged status of services assigned to the APCs selected in 2015 in a future year. CMS intends to review the conditionally packaged status of ancillary services annually. CMS proposes to exclude from this policy certain psychiatry and counseling-related services as well as certain low cost drug administration services. CMS also is proposing to exclude certain preventative services from this policy. The excluded preventative services are listed in the table below.

Preventative Services Exempted from the Ancillary Service Packaging Policy		
HCPCS Code	Short Descriptor	APC
76977	Us bone density measure	0340
77078	Ct bone density axial	0260
77080	Dxa bone density axial	0261
77081	Dxa bone density/peripheral	0260
G0117	Glaucoma scrn hgh risk direc	0260
G0118	Glaucoma scrn hgh risk direc	0230
G0130	Single energy x-ray study	0230
G0389	Ultrasound exam aaa screen	0265
G0404	Ekg tracing for initial prev	0450
Q0091	Obtaining screen pap smear	0450

CMS also is proposing to delete status indicator "X" (ancillary services) because the majority of the services assigned to status indicator "X" are proposed to be assigned to status indicator "Q1" (STV-Packaged Codes). Services currently assigned status indicator "X" that are not proposed to be conditionally packaged under this policy will be assigned to status indicator "S," which specifies separate payment and indicates that the services are not subject to multiple procedure reduction. The APCs that CMS proposes for conditional packaging as ancillary services in CY 2015 are listed in the table below.

APCs for Proposed Conditionally Packaged Ancillary Services for CY 2015			
APC	Proposed CY 2015 OPPS Geometric Mean Cost	Proposed CY 2015 OPPS SI	Group Title
0012	$76.29	Q1	Level I Debridement & Destruction
0060	$20.64	Q1	Manipulation Therapy
0077	$52.64	Q1	Level I Pulmonary Treatment
0099	$81.27	Q1	Electrocardiograms/Cardiography
0215	$104.63	Q1	Level I Nerve and Muscle Services
0230	$55.00	Q1	Level I Eye Tests & Treatments
0260	$62.43	Q1	Level I Plain Film Including Bone Density Measurement
0261	$99.85	Q1	Level II Plain Film Including Bone Density Measurement
0265	$96.51	Q1	Level I Diagnostic and Screening Ultrasound
0340	$64.78	Q1	Level II Minor Procedures

APCs for Proposed Conditionally Packaged Ancillary Services for CY 2015			
APC	Proposed CY 2015 OPPS Geometric Mean Cost	Proposed CY 2015 OPPS SI	Group Title
0342	$56.99	Q1	Level I Pathology
0345	$78.83	Q1	Level I Transfusion Laboratory Procedures
0364	$42.69	Q1	Level I Audiometry
0365	$123.21	Q1	Level II Audiometry
0367	$166.31	Q1	Level I Pulmonary Tests
0420	$130.93	Q1	Level III Minor Procedures
0433	$190.21	Q1	Level II Pathology
0450	$29.91	Q1	Level I Minor Procedures
0624	$83.61	Q1	Phlebotomy and Minor Vascular Access Device Procedures
0690	$37.25	Q1	Level I Electronic Analysis of Devices
0698	$106.17	Q1	Level II Eye Tests & Treatments

(ii) Prosthetic Supplies

Implantable prosthetic devices are packaged in the OPPS under 42 C.F.R. § 419.2(b)(11). It is common for implantable prosthetic devices to be provided as a part of a device system, which includes nonimplantable prosthetic supplies that are integral to the functioning of the medical device. Because these supplies are integral to the overall function of the implanted prosthetic and in light of CMS's goal of packaging items and services that are typically integral, ancillary, supportive, dependent, or adjunctive to a primary service, CMS believes that it is most consistent with a prospective payment system to package the payment of prosthetic supplies (along with the implantable prosthetic device) into the surgical procedure that implants the prosthetic device. Payment for patients requiring replacement supplies at a later time than the initial surgical procedure and outside of the hospital would be made under the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule.

5. Proposed OPPS Payment Changes for Drugs, Biologicals, and Radiopharmaceuticals

CMS proposes to use the same methodology and policies to establish payment for drugs, biologicals, and radiopharmaceuticals with pass-through status in CY 2015 as the agency used in 2014; these products will continue to be reimbursed at average sales price (ASP) plus 6 percent, as required by statute. CMS also proposes to pay for separately payable drugs and biologicals at ASP+6 percent. The packaging threshold is proposed to remain the same at $90. CMS proposes to establish the high/low cost threshold based on the weighted average mean unit cost for all skin substitute products from CY 2013 claims data (which is proposed to be $27 per cm^2).

a. Pass-through Payment for Drugs and Biologicals

CMS proposes to continue pass-through status in CY 2015 for 22 drugs and biologicals. Eligible products, listed below, will continue to be paid at ASP+6 percent, with quarterly updates. Policy packaged drugs (including contrast agents; diagnostic radiopharmaceuticals; anesthesia drugs; drugs, biologicals, and radiopharmaceuticals that function as supplies when used in a diagnostic test

or procedure; and drugs and biologicals that function as supplies when used in a surgical procedure) still are eligible to receive pass-through status, and, if it is granted, they will be reimbursed at ASP+6 percent for 2 to 3 years. This reimbursement rate is equivalent to the rate these drugs and biologicals would receive in the physician's office setting in CY 2015.

Proposed Drugs and Biologicals with Pass-Through Status in CY 2015

Proposed CY 2015 HCPCS Code	CY 2015 Long Descriptor	Proposed CY 2015 SI	Proposed CY 2015 APC
A9520	Technetium Tc 99m tilmanocept, diagnostic, up to 0.5 millicuries	G	1463
C9021	Injection, obinutuzumab, 10 mg	G	1476
C9022	Injection, elosulfase alfa, 1mg	G	1480
C9132	Prothrombin complex concentrate (human), Kcentra, per i.u. of Factor IX activit	G	9132
C9133	Factor ix (antihemophilic factor, recombinant), Rixubus, per i.u.	G	1467
C9134	Injection, Factor XIII A-subunit, (recombinant), per 10 i.u.	G	1481
C9441	Injection, ferric carboxymaltose, 1 mg	G	9441
C9497	Loxapine, inhalation powder, 10 mg	G	9497
J1446	Injection, tbo-filgrastim, 5 micrograms	G	1447
J1556	Injection, immune globulin (Bivigam), 500 mg	G	9130
J3060	Injection, taliglucerase alfa, 10 units	G	9294
J7315	Mitomycin, ophthalmic, 0.2 mg	G	1448
J7316	Injection, Ocriplasmin, 0.125mg	G	9298
J7508	Tacrolimus, Extended Release, Oral, 0.1 mg	G	1465
J9047	Injection, carfilzomib, 1 mg	G	9295
J9262	Injection, omacetaxine mepesuccinate, 0.01 mg	G	9297
J9354	Injection, ado-trastuzumab emtansine, 1 mg	G	9131
J9371	Injection, Vincristine Sulfate Liposome, 1 mg	G	1466
J9400	Injection, Ziv-Aflibercept, 1 mg	G	9296
Q4121	Theraskin, per square centimeter	G	1479
Q4122	Dermacell, per square centimeter	G	1419
Q4127	Talymed, per square centimeter	G	1449

CMS proposes that the pass-through status of 9 drugs and biologicals, listed below, will expire on December 31, 2014.

Proposed Drugs and Biologicals with Expiring Pass-Through Status in CY 2014

Proposed CY 2015 HCPCS Code	Proposed CY 2015 Long Descriptor	Proposed CY 2015 SI	Proposed CY 2015 APC
C9290	Injection, bupivacaine liposome, 1 mg	N	N/A
C9293	Injection, glucarpidase, 10 units	K	9293
J0178	Injection, aflibercept, 1 mg vial	K	1420
J0716	Injection, centruroides (scorpion) immune (ab)2, up to 120 milligrams	K	1431
J9019	Injection, asparaginase (erwinaze), 1,000 iu	K	9289
J9306	Injection, pertuzumab, 1 mg	K	1471
Q4131	EpiFix, per square centimeter	N	N/A
Q4132	Grafix core, per square centimeter	N	N/A

Proposed CY 2015 HCPCS Code	Proposed CY 2015 Long Descriptor	Proposed CY 2015 SI	Proposed CY 2015 APC
Q4133	Grafix prime, per square centimeter	N	N/A

b. Pass-through Payment for Radiopharmaceuticals

Consistent with its CY 2014 policy for diagnostic and therapeutic radiopharmaceuticals, CMS proposes to provide payment for both diagnostic and therapeutic radiopharmaceuticals that are granted pass-through status based on the ASP methodology. For purposes of pass-through payment, CMS considers radiopharmaceuticals to be drugs under the OPPS. Therefore, if a diagnostic or therapeutic radiopharmaceutical receives pass-through status during CY 2015, CMS proposes to follow the standard ASP methodology to determine the pass-through payment rate that drugs receive, resulting in a payment rate of ASP+6 percent. If ASP data are not available for a radiopharmaceutical, CMS proposes to provide pass-through payment at Wholesale Acquisition Cost (WAC) + 6 percent, the equivalent payment provided to pass-through drugs and biologicals without ASP information. If WAC is not available, payment would be based on 95 percent of the radiopharmaceutical's most recent Average Wholesale Price (AWP).

c. Proposed Pass-Through Evaluation Process for Skin Substitutes

Since 2001, skin substitutes have been evaluated for pass-through status through the drug, biological, and radiopharmaceutical pass-through process. Due in large part to the similarities between implantable biologicals and skin substitutes, in CY 2014, CMS packaged skin substitutes under the policy that packages all drugs and biologicals that function as supplies when used in a surgical procedure. CMS believes that the similarities between implantable biologicals and skin substitutes support similar treatment under the OPPS device pass-through process, which has been the evaluation methodology for implantable biologicals since 2010. CMS proposes that applications for pass-through payment for skin substitutes be evaluated using the medical device pass-through process and payment methodology beginning on and after January 1, 2015, rather than through the drug, biological, and radiopharmaceutical pass-through process.

d. Payment for Drugs, Biologicals, and Radiopharmaceuticals without Pass-Through Status

i. Threshold-Packaged Drugs, Biologicals, and Radiopharmaceuticals

CMS proposes to continue indexing the packaging threshold using its historical methodology, which results in a packaging threshold for drugs and biologicals of $90 per day – the same threshold that was used in CY 2014. Drugs and biologicals with a per day cost greater than $90 would be separately payable (except for policy-packaged items such as diagnostic radiopharmaceuticals; contrast agents; anesthesia drugs; drugs, biologicals, and radiopharmaceuticals that function as supplies when used in a diagnostic test or procedure; and drugs and biologicals that function as supplies when used in a surgical procedure, which CMS proposes to package regardless of cost).

ii. Proposed High/Low Cost Threshold for Packaged Skin Substitutes

In the CY 2014 OPPS final rule, CMS unconditionally packaged skin substitute products into their associated surgical procedures as part of a broader policy to package drugs and biologicals that function as supplies when used in a surgical procedure. CMS finalized a methodology that divides the skin substitutes into a high cost group and a low cost group for packaging purposes. For CY

2014, assignment to the high cost or low cost skin substitute group depended upon a comparison of the July 2013 ASP + 6 percent payment amount for each skin substitute to the weighted average payment per unit for all skin substitutes (which, for CY 2014, was $32 per cm^2).

Stakeholders subsequently have expressed concerns that using ASP to determine a product's placement in the high or low cost category may unfairly disadvantage the limited number of skin substitute products sold in large sizes and that using a weighted average ASP to establish the high/low cost categories, combined with the drug pass-through policy, will lead unstable high/low cost skin substitute categories in the future. In response to these comments, CMS proposes to maintain the high/low cost APC structure for skin substitute procedures in CY 2015, but the agency proposes to revise the current methodology used to establish the high/low cost threshold.

For CY 2015, CMS proposes to establish the high/low cost threshold based on the weighted average mean unit cost (MUC) for all skin substitute products from CY 2013 claims data (which is proposed to be $27 per cm^2). Skin substitutes with a MUC above $27 per cm^2 using CY 2013 claims are proposed to be classified in the high cost group and those with a MUC at or below $27 per cm^2 are proposed to be classified in the low cost group. CMS proposes to continue the current policy that skin substitutes with pass-through status will be assigned to the high cost category for CY 2015. Skin substitutes with pricing information but without claims data to calculate a MUC will be assigned to either the high or low cost category based on the product's ASP + 6 percent or 95 percent of AWP. CMS also is proposing that any new skin substitute without pricing information will be assigned to the low cost category until pricing becomes available. The chart below shows the current high/low cost status for each skin substitute product and the proposed 2015 high/low cost status based on the weighted average MUC threshold of $27.

Proposed Skin Substitutes Assignments to High Cost and Low Cost Groups				
CY 2014 HCPCS Code	CY 2014 Short descripton	Proposed CY 2015 SI	CY 2014 High/low status based on weighted ASP	Proposed CY 2015 High/low status based on weighted MUC
C9358	SurgiMend, fetal	N	Low	Low
C9360	SurgiMend, neonatal	N	Low	Low
C9363	Integra Meshed Bil Wound Mat	N	Low	High
Q4101	Apligraf	N	High	High
Q4102	Oasis wound matrix	N	Low	Low
Q4103	Oasis burn matrix	N	Low	Low
Q4104	Integra MNWD	N	Low	High
Q4105	Integra DRT	N	Low	High
Q4106	Dermagraft	N	High	High
Q4107	Graftjacket	N	High	High
Q4108	Integra matrix	N	Low	High
Q4110	Primatrix	N	High	High
Q4111	Gammagraft	N	Low	Low
Q4115	Alloskin	N	Low	Low
Q4116	Alloderm	N	High	High
Q4117	Hyalomatrix	N	Low	Low
Q4119	Matristem wound matrix	N	Low	Low
Q4120	Matristem burn matrix	N	Low	Low
Q4121	Theraskin	G	High	High
Q4122	Dermacell	G	High	High

Proposed Skin Substitutes Assignments to High Cost and Low Cost Groups				
CY 2014 HCPCS Code	CY 2014 Short descripton	Proposed CY 2015 SI	CY 2014 High/low status based on weighted ASP	Proposed CY 2015 High/low status based on weighted MUC
Q4123	Alloskin	N	Low	Low
Q4124	Oasis tri-layer wound matrix	N	Low	Low
Q4125	Arthroflex	N	High	High
Q4126	Memoderm/derma/tranz/integup	N	High	High
Q4127	Talymed	G	High	High
Q4128	Flexhd/Allopatchhd/matrixhd	N	Low	High
Q4129	Unite biomatrix	N	Low	Low
Q4131	Epifix	N	High	High
A4132	Grafix core	N	High	High
Q4133	Grafix prime	N	High	High
Q4134	hMatrix	N	High	High
Q4135	Mediskin	N	Low	High
Q4136	EZderm	N	Low	Low
Q4137	Amnioexcel or biodexcel, 1cm	N	Low	Low
Q4138	BioDfence DryFlex, 1cm	N	Low	Low
Q4140	Biodfence 1cm	N	Low	Low
Q4141	Alloskin ac, 1 cm	N	Low	Low
Q4142	Xcm biologic tiss matrix 1cm	N	Low	Low
Q4143	Repriza, 1cm	N	Low	Low
Q4146	Tensix, 1cm	N	Low	Low
Q4147	Architect ecm, 1cm	N	High	High
Q4148	Neox 1k, 1cm	N	High	High

iii. Separately Payable Drugs and Biologicals

For CY 2015, CMS proposes to continue paying for separately payable drugs and biologicals at ASP + 6 percent, the statutory default amount, as provided in §1833(t)(14)(A)(iii)(II) of the Social Security Act (SSA). This reimbursement rate is equivalent to the rate provided for drugs administered in the physician's office setting in CY 2015.

iv. Separately Payable Therapeutic Radiopharmaceuticals

CMS proposes to continue to reimburse all nonpass-through, separately payable therapeutic radiopharmaceuticals under the ASP methodology adopted for separately payable drugs and biologicals. Therefore, CMS proposes for CY 2015 to pay all nonpass-through, separately payable therapeutic radiopharmaceuticals at ASP + 6 percent, based on the statutory default described in §1833(t)(14)(A)(iii)(II) of the SSA.

If ASP information is unavailable for a therapeutic radiopharmaceutical, CMS proposes to rely on mean unit cost data derived from hospital claims data to set the payment rates. CMS will update the payment rates for separately payable therapeutic radiopharmaceuticals, according to the agency's usual process for updating the payment rates for separately payable drugs and biologicals, on a quarterly basis if updated ASP information is available.

v. Payment for Blood Clotting Factors

For CY 2015, CMS proposes to pay for blood clotting factors at ASP+6 percent, consistent with its proposed payment policy for other nonpass-through separately payable drugs and biologicals, and to continue its policy of updating the furnishing fee. The proposed furnishing fee update is based on the percentage increase in the Consumer Price Index (CPI) for medical care for the 12-month period ending with June of the previous year. Because the Bureau of Labor Statistics releases the applicable CPI data after the physician fee schedule (PFS) and OPPS proposed rules are published, CMS is not able to include the actual updated furnishing fee in the proposed rules but will announce the actual figure for the percent change in the applicable CPI and the updated furnishing fee calculated based on that figure through applicable program instructions and posting on the CMS web site. The CY 2014 furnishing fee is $0.192 per unit.

vi. Payment for Nonpass-Through Drugs, Biologicals, and Radiopharmaceuticals with HCPCS Codes, but without OPPS Hospital Claims Data

For CY 2015, CMS proposes to provide payment for new drugs, biologicals, and therapeutic radiopharmaceuticals that do not have pass-through status at ASP + 6 percent, consistent with the proposed CY 2015 payment methodology for other separately payable nonpass-through drugs, biologicals, and therapeutic radiopharmaceuticals.

For CY 2015, CMS proposes to package payment for all new nonpass-through policy-packaged products (diagnostic radiopharmaceuticals; contrast agents; anesthesia drugs; drugs, biologicals, and radiopharmaceuticals that function as supplies when used in a diagnostic test or procedure, and drugs and biologicals that function as supplies when used in a surgical procedure) with HCPCS codes but without claims data.

In the absence of ASP data, CMS proposes to continue its policy of using the WAC to establish the initial payment rate for new nonpass-through drugs and biologicals with HCPCS codes, but which are without OPPS claims data and are not subject to the proposed packaging policies. If the WAC is also unavailable, CMS would continue its policy of making payment at 95 percent of the product's most recent AWP.

With respect to the new, nonpass-through drugs, biologicals, and therapeutic radiopharmaceuticals for which CMS does not have ASP data, CMS proposes that once their ASP data become available in later quarterly submissions, their payment rates under the OPPS would be adjusted so that the rates would be based on the ASP methodology and set to the proposed ASP-based amount for items that have not been granted pass-through status.

CMS also proposes to continue to base the initial payment for new therapeutic radiopharmaceuticals with HCPCS codes, but which do not have pass-through status and are without claims data, on the WACs for these products if ASP data for these therapeutic radiopharmaceuticals are not available. If the WACs are also unavailable, CMS proposes to make payment for new therapeutic radiopharmaceuticals at 95 percent of the products' most recent AWP.

vii. Blood and Blood Products

For CY 2015, CMS proposes to continue to establish payment rates for blood and blood products using the agency's blood-specific CCR methodology, using actual or simulated CCRs from the most recently available hospital cost reports to convert hospital charges for blood and blood products to costs. This methodology has been CMS's standard rate-setting methodology for blood and blood products since CY 2005.

As discussed above, CMS proposes C-APCs that would provide all-inclusive payments for certain device-dependent procedures. Under this proposal, CMS would include the costs of blood and blood products when calculating the overall costs of these C-APCs and would continue to apply the blood-specific CCR methodology when calculating the costs of the blood and blood products that appear on claims with services assigned to the C-APCs. Because the costs of blood and blood products would be reflected in the overall costs of the C-APCs, however, CMS proposes not to make separate payments for blood and blood products when they appear on the same claims as services assigned to C-APCs.

6. Pass-Through Payments for Devices

There is currently one device category eligible for pass-through payments: HCPCS code C1841 (Retinal prosthesis, includes all internal and external components), which CMS made effective for pass-through payment as of October 1, 2013. At the end of CY 2015, the device category will have been eligible for pass-through payment for more than 2 years. Therefore, CMS proposes an expiration date for pass-through payment for HCPCS code C1841 of December 31, 2015 and that, effective January 1, 2016, HCPCS code C1841 no longer will be eligible for pass-through payment status. After December 31, 2015, CMS proposes to package the cost of HCPCS code C1841 into the costs related to the procedures with which it is reported in claims data.

7. Proposed Estimate of OPPS Transitional Pass-Through Spending for Drugs, Biologicals, Radiopharmaceuticals, and Devices

CMS estimates that the total estimated pass-through spending for device categories for CY 2015 would be approximately $10.5 million and that the total estimated pass-through spending for drugs and biologicals would be approximately $5 million, for a total of approximately $15.5 million or 0.03 percent of the total projected OPPS payments for CY 2015.

8. Payment for Drug Administration Services

For CY 2015, CMS is not proposing to package low-cost drug administration services as part of its ancillary services packaging policy. However, CMS is examining various alternative payment policies for drug administration services, including the associated drug administration add-on codes.

A chart showing the current and proposed drug administration payment rates is provided below.

Comparison of Hospital Outpatient PPS Drug Administration Rates, 2014 and Proposed 2015

		2014			Proposed 2015				
HCPCS Code	Short Descriptor	SI	APC	Payment Rate	CI	SI	APC	Payment Rate	Change 2014-2015
90461	Im admin each addl component	B				B			
90471	Immunization admin	S	0437	$43.78		S	0437	$52.39	19.7%
90472	Immunization admin each add	N				N			
90473	Immune admin oral/nasal	S	0437	$43.78		S	0437	$52.39	19.7%
90474	Immune admin oral/nasal addl	N				N			
96360	Hydration iv infusion init	S	0438	$105.90		S	0438	$106.21	0.3%
96361	Hydrate iv infusion add-on	S	0436	$29.50		S	0436	$33.01	11.9%
96365	Ther/proph/diag iv inf init	S	0439	$172.18		S	0439	$173.12	0.5%
96366	Ther/proph/diag iv inf addon	S	0436	$29.50		S	0436	$33.01	11.9%
96367	Tx/proph/dg addl seq iv inf	S	0437	$43.78		S	0437	$52.39	19.7%
96368	Ther/diag concurrent inf	N				N			
96369	Sc ther infusion up to 1 hr	S	0439	$172.18		S	0439	$173.12	0.5%
96370	Sc ther infusion addl hr	S	0437	$43.78		S	0437	$52.39	19.7%
96371	Sc ther infusion reset pump	N				N			
96372	Ther/proph/diag inj sc/im	S	0437	$43.78		S	0437	$52.39	19.7%
96373	Ther/proph/diag inj ia	S	0438	$105.90		S	0438	$106.21	0.3%
96374	Ther/proph/diag inj iv push	S	0438	$105.90		S	0438	$106.21	0.3%
96375	Tx/pro/dx inj new drug addon	S	0437	$43.78	CH	S	0436	$33.01	-24.6%
96376	Tx/pro/dx inj same drug adon	N				N			
96379	Ther/prop/diag inj/inf proc	S	0436	$29.50		S	0436	$33.01	11.9%
96401	Chemo anti-neopl sq/im	S	0438	$105.90		S	0438	$106.21	0.3%
96402	Chemo hormon antineopl sq/im	S	0437	$43.78		S	0437	$52.39	19.7%
96405	Chemo intralesional up to 7	S	0437	$43.78		S	0437	$52.39	19.7%
96406	Chemo intralesional over 7	S	0439	$172.18		S	0439	$173.12	0.5%
96409	Chemo iv push sngl drug	S	0439	$172.18		S	0439	$173.12	0.5%
96411	Chemo iv push addl drug	S	0437	$43.78		S	0437	$52.39	19.7%
96413	Chemo iv infusion 1 hr	S	0440	$299.53		S	0440	$282.61	-5.6%
96415	Chemo iv infusion addl hr	S	0437	$43.78		S	0437	$52.39	19.7%
96416	Chemo prolong infuse w/pump	S	0440	$299.53		S	0440	$282.61	-5.6%
96417	Chemo iv infus each addl seq	S	0437	$43.78		S	0437	$52.39	19.7%
96420	Chemo ia push tecnique	S	0438	$105.90		S	0438	$106.21	0.3%
96422	Chemo ia infusion up to 1 hr	S	0440	$299.53		S	0440	$282.61	-5.6%
96423	Chemo ia infuse each addl hr	S	0438	$105.90		S	0438	$106.21	0.3%
96425	Chemotherapy infusion method	S	0440	$299.53		S	0440	$282.61	-5.6%
96440	Chemotherapy intracavitary	S	0439	$172.18		S	0439	$173.12	0.5%
96446	Chemotx admn prtl cavity	S	0439	$172.18		S	0439	$173.12	0.5%
96450	Chemotherapy into cns	S	0440	$299.53		S	0440	$282.61	-5.6%
96521	Refill/maint portable pump	S	0439	$172.18		S	0439	$173.12	0.5%
96522	Refill/maint pump/resvr syst	S	0439	$172.18		S	0439	$173.12	0.5%
96523	Irrig drug delivery device	Q1	0624	$80.98		Q1	0624	$79.86	-1.4%

96542	Chemotherapy injection	S	0438	$105.90		S	0438	$106.21	0.3%
96549	Chemotherapy unspecified	S	0436	$29.50		S	0436	$33.01	11.9%

9. Proposed OPPS Payment for Hospital Outpatient Visits

For CY 2015, CMS proposes to continue the policy established in CY 2014 that HCPCS code G0463 (Hospital outpatient clinic visit for assessment and management of a patient) will represent any and all clinic visits under the OPPS and be assigned to APC 0634. CMS also proposes to use CY 2013 claims data to develop the CY 2015 OPPS payment rates for HCPCS code G0463 based on the total geometric mean cost of the levels one through five CPT evaluation and management codes for clinic visits previously recognized under the OPPS. In addition, as established for CY 2014, CMS proposes for CY 2015 not to recognize a distinction between new and established patient clinic visits.

CMS continues to believe that additional study is needed to assess the most suitable payment structure for emergency department visits. For CY 2015, CMS proposes to continue to use its existing methodology to recognize the existing CPT codes for Type A emergency department visits as well as the five HCPCS codes that apply to Type B emergency department visits and to establish the CY 2015 proposed OPPS payment rates using CMS's established standard process. CMS may propose changes to the coding and APC assignments for emergency department visits in future rulemaking.

10. Proposed Payment Changes for Composite APCs

a. Low Dose Rate (LDR) Prostate Brachytherapy Composite APC (APC 8001)

For CY 2015, CMS proposes to continue paying for LDR prostate brachytherapy services using the composite APC methodology proposed and implemented for CY 2008 through CY 2014. The proposed cost for composite APC 8001 is approximately $3,669, and the proposed payment rate is $3,504.02. This proposed payment rate is a decrease from the CY 2014 payment for this composite APC, which is $3,844.64.

b. Multiple Imaging Composite APCs (APCs 8004, 8005, 8006, 8007, and 8008)

For CY 2015, CMS proposes to continue paying for all multiple imaging procedures within an imaging family performed on the same date of service using the multiple imaging composite payment methodology. To calculate the proposed costs, CMS used the same methodology that was used to calculate the final CY 2013 and CY 2014 costs for these composite APCs. The charts below show the proposed OPPS imaging families and multiple imaging procedure composite APCs.

Composite APC	Description	2014 Payment	Proposed 2015 Payment
8004	Ultrasound Composite	$285.58	$285.37
8005	CT and CTA without Contrast Composite	$306.30	$319.59
8006	CT and CTA with Contrast Composite	$548.28	$532.69
8007	MRI and MRA without Contrast Composite	$621.30	$611.45
8008	MRI and MRA with Contrast Composite	$927.43	$914.55

Proposed OPPS Imaging Families and Multiple Imaging Procedure Composite APCs

Family 1 – Ultrasound – APC 8004

76604	Us exam, chest
76700	Us exam, abdom, complete
76705	Echo exam of abdomen
76770	Us exam abdo back wall, comp
76775	Us exam abdo back wall, lim
76776	Us exam k transpl w/Doppler
76831	Echo exam, uterus
76856	Us exam, pelvic, complete
76870	Us exam, scrotum
76857	Us exam, pelvic, limited

Family 2 - CT and CTA with and without Contrast
CT and CTA without Contrast Composite – APC 8005*

70450	Ct head/brain w/o dye
70480	Ct orbit/ear/fossa w/o dye
70486	Ct maxillofacial w/o dye
70490	Ct soft tissue neck w/o dye
71250	Ct thorax w/o dye
72125	Ct neck spine w/o dye
72128	Ct chest spine w/o dye
72131	Ct lumbar spine w/o dye
72192	Ct pelvis w/o dye
73200	Ct upper extremity w/o dye
73700	Ct lower extremity w/o dye
74150	Ct abdomen w/o dye
74261	Ct colonography, w/o dye
74176	Ct angio abd & pelvis

CT and CTA with Contrast Composite – APC 8006

70487	Ct maxillofacial w/dye
70460	Ct head/brain w/dye
70470	Ct head/brain w/o & w/dye
70481	Ct orbit/ear/fossa w/dye
70482	Ct orbit/ear/fossa w/o & w/dye
70488	Ct maxillofacial w/o & w/dye
70491	Ct soft tissue neck w/dye
70492	Ct sft tsue nck w/o & w/dye
70496	Ct angiography, head
70498	Ct angiography, neck
71260	Ct thorax w/dye
71270	Ct thorax w/o & w/dye

71275	Ct angiography, chest
72126	Ct neck spine w/dye
72127	Ct neck spine w/o & w/dye
72129	Ct chest spine w/dye
72130	Ct chest spine w/o & w/dye
72132	Ct lumbar spine w/dye
72133	Ct lumbar spine w/o & w/dye
72191	Ct angiograph pelv w/o & w/dye
72193	Ct pelvis w/dye
72194	Ct pelvis w/o & w/dye
73201	Ct upper extremity w/dye
73202	Ct uppr extremity w/o & w/dye
73206	Ct angio upr extrm w/o & w/dye
73701	Ct lower extremity w/dye
73702	Ct lwr extremity w/o & w/dye
73706	Ct angio lwr extr w/o & w/dye
74160	Ct abdomen w/dye
74170	Ct abdomen w/o & w/dye
74175	Ct angio abdom w/o & w/dye
74262	Ct colonography, w/dye
75635	Ct angio abdominal arteries
74177	Ct angio abd&pelv w/contrast
74178	Ct angio abd & pelv 1+ regns

* If a “without contrast” CT or CTA procedure is performed during the same session as a “with contrast” CT or CTA procedure, the I/OCE will assign APC 8006 rather than APC 8005.

Family 3 – MRI and MRA with and without Contrast
MRI and MRA without Contrast Composite – APC 8007*

70336	Magnetic image, jaw joint
70540	Mri orbit/face/neck w/o dye
70544	Mr angiography head w/o dye
70547	Mr angiography neck w/o dye
70551	Mri brain w/o dye
70554	Fmri brain by tech
71550	Mri chest w/o dye
72141	Mri neck spine w/o dye
72146	Mri chest spine w/o dye
72148	Mri lumbar spine w/o dye
72195	Mri pelvis w/o dye
73218	Mri upper extremity w/o dye
73221	Mri joint upr extrem w/o dye
73718	Mri lower extremity w/o dye
73721	Mri jnt of lwr extre w/o dye
74181	Mri abdomen w/o dye
75557	Cardiac mri for morph

75559	Cardiac mri w/stress img
C8901	MRA w/o cont, abd
C8904	MRI w/o cont, breast, uni
C8907	MRI w/o cont, breast, bi
C8910	MRA w/o cont, chest
C8913	MRA w/o cont, lwr ext
C8919	MRA w/o cont, pelvis
C8932	MRA, w/o dye, spinal canal
C8935	MRA, w/o dye, upper extr

MRI and MRA with Contrast Composite – APC 8008

70549	Mr angiograph neck w/o & w/dye
70542	Mri orbit/face/neck w/dye
70543	Mri orbt/fac/nck w/o & w/dye
70545	Mr angiography head w/dye
70546	Mr angiograph head w/o & w/dye
70547	Mr angiography neck w/o dye
70548	Mr angiography neck w/dye
70552	Mri brain w/dye
70553	Mri brain w/o & w/dye
71551	Mri chest w/dye
71552	Mri chest w/o & w/dye
72142	Mri neck spine w/dye
72147	Mri chest spine w/dye
72149	Mri lumbar spine w/dye
72156	Mri neck spine w/o & w/dye
72157	Mri chest spine w/o & w/dye
72158	Mri lumbar spine w/o & w/dye
72196	Mri pelvis w/dye
72197	Mri pelvis w/o & w/dye
73219	Mri upper extremity w/dye
73220	Mri uppr extremity w/o & w/dye
73222	Mri joint upr extrem w/dye
73223	Mri joint upr extr w/o & w/dye
73719	Mri lower extremity w/dye
73720	Mri lwr extremity w/o & w/dye
73722	Mri joint of lwr extr w/dye
73723	Mri joint lwr extr w/o & w/dye
74182	Mri abdomen w/dye
74183	Mri abdomen w/o & w/dye
75561	Cardiac mri for morph w/dye
75563	Card mri w/stress img & dye
C8900	MRA w/cont, abd
C8902	MRA w/o fol w/cont, abd
C8903	MRI w/cont, breast, uni
C8905	MRI w/o fol w/cont, brst, un

C8906	MRI w/cont, breast, bi
C8908	MRI w/o fol w/cont, breast,
C8909	MRA w/cont, chest
C8911	MRA w/o fol w/cont, chest
C8912	MRA w/cont, lwr ext
C8914	MRA w/o fol w/cont, lwr ext
C8918	MRA w/cont, pelvis
C8920	MRA w/o fol w/cont, pelvis
C8931	MRA, w/dye, spinal canal
C8933	MRA, w/o & w/dye, spinal canal
C8934	MRA, w/dye, upper extremity
C8936	MRA, w/o & w/dye, upper extr

* If a "without contrast" MRI or MRA procedure is performed during the same session as a "with contrast" MRI or MRA procedure, the I/OCE will assign APC 8008 rather than APC 8007.

11. Proposed OPPS APC-Specific Policies

a. Image-Guided Breast Biopsy Procedures (APC 0005)

For the CY 2014 OPPS update, the American Medical Association (AMA) CPT Editorial Panel deleted the image-guided breast biopsy CPT code 19102 (Biopsy of breast; percutaneous, needle core, using imaging guidance) and CPT code 19103 (Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance) and replaced these procedure codes with six new CPT codes (specifically, CPT codes 19081, 19082, 19083, 19084, 19085, and 19086) that "bundled" associated imaging services, effective January 1, 2014. The six new CPT codes are differentiated based on whether the imaging services are performed using stereotactic guidance, ultrasound guidance, or magnetic-resonance guidance. For CY 2014, replacement CPT codes 19081, 19083, and 19085 were given an interim assignment of APC 0005 (Level II Needle Biopsy/Aspiration Except Bone Marrow), and CPT codes 19082, 19084, and 19086, which describe add-on procedures, were packaged under CMS's new policy to package all add-on codes.

For CY 2015, in light of a public presentation at the March 2014 meeting of the Advisory Panel on Hospital Outpatient Payment ("HOP Panel"), the HOP Panel's recommendations, and CMS's policy of reviewing APC assignments, CMS proposes to reassign all of the procedures assigned to APCs 0685 and 0037 to either APC 0004 or APC 0005 based on clinical and resource homogeneity. CMS proposes to delete APCs 0685 and 0037.

CMS proposes to continue to assign CPT codes 19081, 19083, and 19085 to APC 0005. CMS also proposes to continue to package payment for add-on CPT codes 19082, 19084, and 19086. The proposed reassignment of the procedures assigned to APCs 0685 and 0037 would result in increased payment rates for both APCs 0004 and 0005. For CY 2015, the proposed payment rate for APC 0004 is approximately $494, which is 20 percent higher than the CY 2014 OPPS payment rate of approximately $411. The proposed payment rate for APC 0005 is approximately $1,062, which is 51 percent higher than the CY 2015 OPPS payment rate of $702. CMS believes that the proposed increased payment rate for APC 0005 is consistent with the HOP Panel's recommendation to reassign CPT codes 19081, 19083, and 19085 to an appropriate APC based on resource utilization and clinical coherence.

The table below shows the proposed status indicators, APC assignments, and payment rates for the image-guided breast biopsy CPT codes 19081 through 19086.

Proposed APCs to Which Image-Guided Breast Biopsy Procedure Codes Would Be Assigned For CY 2015							
CY 2014 CPT code	Long descriptor	CY 2014 SI	CY 2014 APC	CY 2014 payment rate	Proposed CY 2015 SI	Proposed CY 2015 APC	Proposed CY 2015 payment rate
19081	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance	T	0005	$702.08	T	0005	$1,062.28
19082	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)	N	N/A	N/A	N	N/A	N/A
19083	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance	T	0005	$702.08	T	0005	$1,062.28
19084	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)	N	N/A	N/A	N	N/A	N/A
19085	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including magnetic resonance guidance	T	0005	$702.08	T	0005	$1,062.28
19086	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)	N	N/A	N/A	N	N/A	N/A

b. Image-Guided Abscess Drainage Procedures (APCs 0005 and 0007)

For the CY 2014 OPPS update, the AMA CPT Editorial Panel established CPT codes 10030 and 49407 pertaining to image-guided abscess drainage procedures. For CY 2014, CMS gave CPT code 10030 the interim APC assignment of APC 0006 (Level I Incision & Drainage), with a payment rate of $159.66, and gave CPT code 49407 an interim APC assignment of APC 0685, with a payment rate of $757.76.

The HOP Panel recommended that CMS reassign CPT code 49407 and the image-guided breast biopsy procedures to APC 0037. CMS evaluated costs associated with the procedures assigned to the existing four needle biopsy APCs (APC 0004, 0005, 0685, and 0037) and, based on this review, proposes for CY 2015 to reassign the procedures assigned to APCs 0685 and 0037 to either APC 0004 or APC 0005 based on clinical and resource homogeneity and to delete APCs 0685 and 0037. CMS proposes to reassign CPT code 49407 to APC 0005. In response to a presentation at the HOP Panel and HOP Panel recommendations, CMS is also proposing to reassign CPT code 10030 to APC 007 for CY 2015. As shown in the chart below, the proposed new APC assignments would yield higher payments for these codes than those provided in CY 2014.

CY 2014 CPT code	Long descriptor	CY 2014 SI	CY 2014 APC	2014 Payment Rate	Proposed CY 2015 SI	Proposed CY 2015 APC	Proposed 2015 Payment Rate
10030	Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst), soft tissue (eg, extremity, abdominal wall, neck), percutaneous	T	0006	$159.66	T	0007	$908.03
49407	Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, transvaginal or transrectal	T	0685	$757.76	T	0005	$1,062.28

c. Radiation Therapy (APCs 0066, 0067, 0412, 0446, 0648, and 0667)

CMS proposes the following changes to the radiation therapy APCs for CY 2015:

(i) Proposed changes related to correction a violation of the 2 times rule within APC 0664

Due to a violation of the 2 times rule within APC 0064 (Level I Proton Beam Radiation Therapy), CMS proposes to reassign CPT code 77520 from APC 0664 to APC 0412 (Level III Radiation Therapy) and to reassign CPT code 77522 from APC 0664 to APC 0667 because these CPT codes are clinically similar and comparable in geometric mean cost to other services assigned to these APCs. If these reassignments are made, there would be no other codes assigned to APC 0664, so CMS propose to delete APC 0664 for CY 2015. CMS also proposes to rename APC 0667 from "Level II Proton Beam Radiation Therapy" to "Level IV Radiation Therapy" to make the title consistent with other APCs in the radiation therapy series. CMS also proposes to reassign the following three services to the proposed newly renamed APC 0667 for CY 2015: CPT codes 77522, 77523, and 77525.

(ii) Proposed changes related to the deletion of APC 0065

For CY 2015, CMS proposes to delete APC 0065 (IORT, MRgFUS, and MEG) because CMS proposes to reassign the services assigned to APC 0065 to other more appropriate APCs based on clinical similarities and comparable geometric mean cost.

Specifically, CMS proposes to reassign Magnetoencephalography (MEG) CPT codes 95965 and 95966 from APC 0065 to APC 0446 (Level IV Nerve and Muscle Services) and to reassign IORT

CPT codes 77424 and 77425 to C-APC 0648 (Level IV Breast and Skin Surgery). CMS also is proposing to reassign the Magnetic Resonance-Guided Focused Ultrasound Surgery (MRgFUS) HCPCS codes C9734, 0071T, and 0072T and CPT code 0301T from APC 0065 to APC 0066, which CMS proposes to rename "Level V Radiation Therapy." CMS believes that MRgFUS services should be assigned to APC 0066 to align with the assignment of certain stereotactic radiosurgery services (HCPCS codes G0339 and successor CPT code 77373) that were grouped with MRgFUS services prior to CY 2015.

(iii) Renaming of C-APC 0067

CMS proposes to rename APC 0067 from "Level II "Stereotactic Radiosurgery" to "Single Session Cranial Stereotactic Radiosurgery." CMS also is proposing that APC 0067 will be a C-APC in CY 2015.

12. Proposed APC Group Policies

a. Proposed Treatment of New CPT and Level II HCPCS Codes

The level II HCPCS codes listed in the chart below were implemented by CMS in April 2014. CMS is seeking public comments on the proposed status indicators, APC assignments, and payment rates for these Level II HCPCS codes.

New Level II HCPCS Codes Implemented in April 2014				
CY 2014 HCPCS Code	**CY 2014 Long Descriptor**	**Proposed CY 2015 Status Indicator**	**Proposed CY 2015 APC**	**Proposed CY 2015 Payment Rate**
C9021*	Injection, obinutuzumab, 10 mg	G	1476	$54.70
C9739	Cystourethroscopy, with insertion of transprostatic implant; 1 to 3 implants	T	0162	$2,090.89
C9740	Cystourethroscopy, with insertion of transprostatic implant; 1 to 3 implants	T	1564	$4,750.00
Q2052	Services, supplies and accessories used in the home under the Medicare intravenous immune globulin (ivig) demonstration)	N	N/A	N/A

* The proposed payment rates for HCPCS code C9021 is based on published WAC + 6 percent.

In July 2014, CMS implemented additional new level II HCPCS codes, including the code shown in the chart below. CMS is seeking public comments on the proposed status indicators, APC assignments, and payment rates for these Level II HCPCS codes.

New Level II HCPCS Codes Implemented in July 2014				
CY 2014 HCPCS Code	**CY 2014 Long Descriptor**	**Proposed CY 2015 Status Indicator**	**Proposed CY 2015 APC**	**Proposed CY 2015 Payment Rate**
C2644	Brachytherapy source, cesium-131 chloride solution, per millicurie	U	2644	$18.97
C9022*	Injection, elosulfase alfa, 1 mg	G	1480	$226.42
C9134*	Factor XIII (antihemophilic factor,	G	1481	$14.10

	recombinant), Tretten, per 10 i.u.			
Q9970**	Injection, ferric carboxymaltose, 1 mg	G	9441	$1.06
Q9974***	Injection, morphine sulfate, preservative-free for	N	N/A	N/A

* The proposed payment rates for HCPCS code C9022 and C9134 are based on ASP + 6 percent.
** HCPCS code C9441 (Injection, ferric carboxymaltose, 1 mg) was deleted June 30, 2014, and replaced with HCPCS code Q9970, effective July 1, 2014.
*** HCPCS codes J2271 (Injection, morphine sulfate, 100 mg) and J2275 (Injection, morphine sulfate (preservative-free sterile solution), per 10 mg) were replaced with HCPCS code Q9974, effective July 1, 2014. The payment indicator assignment for HCPCS codes J2271 and J2275 was changed to "E" (Not Payable by Medicare), effective July 1, 2014.

In July 2014, CMS implemented new Category III CPT codes, including the codes shown in the chart below. CMS is seeking public comments on the proposed status indicators, APC assignments, and payment rates for these Category III CPT codes.

New Category III CPT Codes Implemented in July 2014				
CY 2014 CPT Code	**CY 2014 Long Descriptor**	**Proposed CY 2015 Status Indicator**	**Proposed CY 2015 APC**	**Proposed CY 2015 Payment Rate**
0347T	Placement of interstitial device(s) in bone for radiostereometric analysis (RSA)	Q2	0420	$125.05
0348T	Radiologic examination, radiostereometric analysis (RSA); spine, (includes, cervical, thoracic and lumbosacral, when performed)	S	0261	$95.36
0349T	Radiologic examination, radiostereometric analysis (RSA); upper extremity(ies), (includes shoulder, elbow and wrist, when performed)	S	0261	$95.36
0350T	Radiologic examination, radiostereometric analysis (RSA); lower extremity(ies), (includes hip, proximal femur, knee and ankle, when performed)	S	0261	$95.36
0351T	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; real time intraoperative	N	N/A	N/A
0352T	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; interpretation and report, real time or referred	B	N/A	N/A
0353T	Optical coherence tomography of breast, surgical cavity; real time intraoperative	N	N/A	N/A
0354T	Optical coherence tomography of breast, surgical cavity; interpretation and report, real time or referred	B	N/A	N/A
0355T	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report	T	0142	$857.73
0356T	Insertion of drug-eluting implant (including punctual dilation and implant removal when performed) into lacrimal canaliculus, each	Q1	0698	$101.41
0358T	Bioelectrical impedance analysis whole body composition assessment, supine position, with interpretation and report	Q1	0340	$61.88
0359T	Behavior identification assessment by the physician or other qualified health care professional, face-to-face with patient and	V	0632	$107.98

New Category III CPT Codes Implemented in July 2014				
CY 2014 CPT Code	**CY 2014 Long Descriptor**	**Proposed CY 2015 Status Indicator**	**Proposed CY 2015 APC**	**Proposed CY 2015 Payment Rate**
	caregiver(s), includes administration of standardized and non-standardized tests, detailed behavior history, patient observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s), and preparation of report			
0360T	Observational behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; first 30 minutes of technician time, face-to-face with the patient	V	0632	$107.98
0361T	Observational behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; each additional 30 minutes of technician time, face-to-face with the patient (List separately in addition to code for primary service)	N	N/A	N/A
0362T	Exposure behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more technicians; first 30 minutes of technician(s) time, face-to-face with the patient	V	0632	$107.98
0363T	Exposure behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more technicians; each additional 30 minutes of technician(s) time, face-to-face with the patient (List separately in addition to code for primary procedure)	N	N/A	N/A
0364T	Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; first 30 minutes of technician time	S	0322	$92.61
0365T	Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; each additional 30 minutes of technician time (List separately in addition to code for primary procedure)	N	N/A	N/A
0366T	Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; first 30 minutes of technician time	S	0325	$65.81

New Category III CPT Codes Implemented in July 2014				
CY 2014 CPT Code	**CY 2014 Long Descriptor**	**Proposed CY 2015 Status Indicator**	**Proposed CY 2015 APC**	**Proposed CY 2015 Payment Rate**
0367T	Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; each additional 30 minutes of technician time (List separately in addition to code for primary procedure)	N	N/A	N/A
0368T	Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional with one patient; first 30 minutes of patient face-to-face time	S	0322	$92.61
0369T	Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional with one patient; each additional 30 minutes of patient face-to-face time (List separately in addition to code for primary procedure)	N	N/A	N/A
0370T	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present)	S	0324	$130.28
0371T	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present)	S	0324	$130.28
0372T	Adaptive behavior treatment social skills group, administered by physician or other qualified health care professional face-to-face with multiple patients	S	0325	$65.91
0373T	Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); first 60 minutes of technicians' time, face-to-face with patient	S	0323	$117.96
0374T	Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); each additional 30 minutes of technicians' time, face-to-face with patient (List separately in addition to code for primary procedure)	N	N/A	N/A

13. Proposed Process for Soliciting New Public Comments for New and Revised CPT Codes That Would Be Released by AMA Before the January 1 Effective Date

For CY 2015, CMS proposes to make changes to the process used to establish APC assignments and status indicators for new and revised CPT codes that are effective January 1. Historically, because the AMA's CPT Editorial Panel's coding cycle occurs concurrently with CMS's calendar year rulemaking cycle for the OPPS and the ASC payment system, CMS has incorporated new CPT codes that are effective January 1 or substantially revised CPT codes into the OPPS final rule with

comment period. CMS establishes interim APC and status indicator assignments for the coming year and requests public comments on the interim assignments. CMS responds to comments and finalizes the APC and status indicator assignments for these CPT codes in the following year's OPPS final rule with comment period.

CMS indicates that a variety of stakeholders have expressed concern about the process that CMS uses to recognize new and revised CPT codes. These stakeholders have urged CMS to publish proposed APCs and status indicators for the new and revised CPT codes that will be effective January 1 in the OPPS proposed rule and request public comments prior to finalizing them for the January 1 implementation date. Stakeholders believe public comments would assist CMS in assigning the CPT codes to appropriate APCs. CMS notes that stakeholders have raised similar concerns regarding CMS's process for assigning interim payment values for new, revised, and potentially misvalued codes under the Medicare PFS. Therefore, CMS also is including proposed policies to address those concerns in the CY 2015 PFS proposed rule.

For CY 2015, CMS proposes to include in the OPPS proposed rule the proposed APC and status indicator assignments for new and revised CPT codes that are effective January 1. CMS would accept public comments on the proposed assignments, and respond to comments and make final APC and status indicator assignments in the OPPS final rules with comment period. The proposed revised process would eliminate CMS's current practice of assigning interim APC and status indicators for the new and revised CPT codes that take effect on January 1 each year.

CMS proposes to create an exception in the case of a code that describes a wholly new service (such as a new technology or new surgical procedure) that has not previously been addressed under the OPPS. For codes that describe new services, CMS would establish interim APC and status indicator assignments in the OPPS final rules with comment period, in accordance with CMS's current process.

Under the proposed policy, when CMS does not receive new and revised codes early enough in its ratesetting process to propose APC and status indicator assignments in the OPPS Proposed Rule for a given year, CMS would create and use HCPCS G-codes that would mirror the predecessor CPT codes and retain the current APC and status indicator assignments for a year until CMS could include proposed assignments in the following year's proposed rule.

CMS proposes to implement this revised process for establishing APC and status indicator assignments for new and revised codes for CY 2016. However, CMS will consider alternative implementation dates to allow time for the AMA CPT Editorial Panel to adjust its schedule in order to avoid having to use numerous HCPCS G-codes.

CMS invites public comments on the following questions in particular:

- Is this proposal preferable to the present process? Are there other alternatives?
- If CMS implements this proposal, should CMS move forward with the changes immediately, or is more time needed to make the transition and, therefore, implementation should be delayed beyond CY 2016?
- Are there alternatives other than the use of HCPCS G-codes that would allow CMS to address the annual CPT code changes through notice and comment rather than interim final rulemaking?

- Is the process CMS have proposed for wholly new services appropriate? How should CMS define new services?
- Are there any classes of services, other than new services, that should remain on an interim final schedule?

14. Proposed OPPS Payments to Certain Cancer Hospitals Described by Section 1886(d)(1)(B)(v) of the SSA

The Secretary of the Department of Health and Human Services was required under section 3138 of the ACA to conduct a study to determine whether costs incurred by cancer hospitals described in section 1886(d)(1)(B)(v) of the SSA (Hospital Inpatient Prospective Payment System (IPPS)-exempt cancer hospitals) exceeded the costs of hospitals furnishing services under section 1833(t) of the SSA (other hospitals furnishing services under the OPPS). The statute instructs the Secretary to provide an appropriate adjustment if the study shows that cancer hospitals' costs with respect to APC groups are determined to be greater than the costs of other hospitals furnishing services under the OPPS.

Based on the study's findings that costs incurred by cancer hospitals were greater than the costs incurred by other OPPS hospitals, CMS finalized a policy to provide a payment adjustment to 11 specified cancer hospitals that reflect the higher outpatient costs. IPPS-exempt cancer hospitals remain eligible for transitional outpatient payments (TOPs) that are designed to ensure that their payments under the OPPS are not lower than they would have been prior to implementation of the OPPS system, and other outlier payments.

For CY 2015, CMS proposes to continue the its policy of providing additional payments to cancer hospitals so that the hospital's payment-to-cost ratio (PCR) with the payment adjustment is equal to the weighted average PCR for the other OPPS hospitals using the most recent submitted or settled cost report data. Based on those data, the payment amount associated with the cancer hospital payment adjustment would be the additional payment needed to result in a proposed target PCR equal to 0.89 for each cancer hospital. For CY 2014, the target PCR for this adjustment was also 0.89.

15. Proposed Hospital Outpatient Outlier Payments

For CY 2015, CMS proposes to continue its policy of estimating outlier payments to be 1.0 percent of the estimated aggregate total payments under the OPPS for outlier payments. To ensure that the estimated CY 2015 aggregate outlier payments would equal 1.0 percent of estimated aggregate total payments under the OPPS, CMS proposes that the hospital outlier threshold be set so that outlier payments would be triggered when the cost of furnishing a service or procedure by hospital exceeds 1.75 times the APC payment amount and exceeds the APC payment rate plus a $3,100 fixed-dollar threshold. If the cost of a service exceeds both thresholds, the outlier payment is calculated as 50 percent of the amount by which the cost of furnishing the service exceeds 1.75 times the APC payment amount.

16. Proposed Procedures That Would be Paid Only as Inpatient Procedures

CMS is not proposing to remove any procedures from the inpatient list for CY 2015.

17. Collecting Data on Services Furnished in Off-Campus Provider-Based Departments

In light of a growing trend toward hospital acquisition of physician practices, integration of those practices as a department of the hospital, and an increase in the delivery of physician's services in a hospital setting, CMS seeks a better understanding of how this trend impacts payments under the PFS and OPPS as well as beneficiary cost-sharing obligations. CMS is particularly interested in this information because the total payment amount for outpatient services made by Medicare is generally higher than the total payment amount made by Medicare when a physician furnished those same services in a freestanding clinic or in a physician's office. The Medicare Payment Advisory Commission (MedPAC) has questioned the appropriateness of increased Medicare payment and beneficiary cost-sharing when physician offices become hospital outpatient departments and has recommended that Medicare pay selected hospital outpatient services at PFS rates.

CMS cites SSA § 1834(c)(2)(M) as granting CMS the authority to engage in data collection to support valuation of services paid under the PFS. CMS is interested in obtaining more information on the frequency and type of services furnished in provider-based departments under this authority to improve the accuracy of the PFS. CMS notes in the PFS proposed rule that the current PFS practice expense methodology primarily distinguishes between the resources involved in furnishing services in either the nonfacility or the facility setting. As more physician practices become hospital-based and are treated as off-campus provider-based departments, CMS wants to develop a better understanding of which practice expense costs are typically incurred by the hospital, the physicians and practitioners in the setting, and whether the facility and nonfacility site of service differentials adequately account for the typical resource costs in light of these new ownership arrangements.

CMS seeks to gather information on the extent to which this shift is occurring. In the CY 2014 OPPS final rule, CMS requested public comments regarding the best method for collecting information and data that would allow CMS to analyze the frequency, type, and payment for physicians' and outpatient hospital services furnished in off-campus provider-based hospital outpatient departments. Based on the comments received, CMS proposes to create a HCPCS modifier to be reported beginning January 1, 2015 with every code for physicians' services and outpatient hospital services furnished in an off-campus provider-based department of a hospital on both the CMS-1500 claim form for physicians' services and the UB-04 form for hospital outpatient services. CMS notes that an off-campus facility is provider-based if it meets the requirements of 42 C.F.R. § 413.65, and "campus" is defined at 42 C.F.R. 413.65(a)(2). CMS seeks public comment on whether the use of a modifier code is the best mechanism for collecting this service-level data in the hospital outpatient department.

18. Proposed Exceptions to the 2 Times Rule

Per section 1833(t)(2) of the SSA, the items and services within an APC group cannot be considered comparable with respect to the use of resources if the highest cost for an item or service in the group is more than 2 times greater than the lowest cost for an item or service within the same group. The Secretary of the Department of Health and Human Services is authorized to make exceptions to the 2 times rule in unusual cases, however, such as low-volume items and services. In the CY 2015 Proposed Rule, CMS proposes the following nine exceptions to the 2 times rule:

Proposed APC Exceptions to the 2 Times Rule for CY 2015	
Proposed CY 2015 APC	**Proposed CY 2015 APC Title**
0012	Level I Debridement & Destruction
0015	Level II Debridement & Destruction
0057	Bunion Procedures
0066	Level V Radiation Therapy
0330	Dental Procedures
0433	Level II Pathology
0450	Level I Minor Procedures
0634	Hospital Clinic Visits
0661	Level III Pathology

19. Proposed Updates to the ASC Payment System

a. Proposed Payment for LDR Prostate Brachytherapy Services

CMS is not proposing any changes to its current policy regarding ASC payment for LDR prostate brachytherapy services for CY 2015.

20. Hospital Outpatient Quality Reporting (OQR) Program Updates

In the CY 2015 Proposed Rule, CMS proposes to refine the criteria for determining when a measure is "topped-out." CMS considers a finalized measure to be "topped-out" when measure performance among hospitals is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made. In order to establish "topped-out" status, CMS proposes that a measure under the Hospital OQR Program is "topped-out" when it meets both of the following criteria:

(1) Statistically indistinguishable performance at the 75th and 90th percentiles; and
(2) A truncated coefficient of variation less than or equal to 0.10.

CMS proposes to remove three measures from the Hospital OQR Program for the CY 2017 payment determination and subsequent years. CMS proposes to remove OP-4 (Aspirin at Arrival), OP-6 (Timing of Antibiotic Prophylaxis), and OP-7 (Prophylactic Antibiotic Selection for Surgical Patients) because these measures meet both CMS's previously finalized criteria for being "topped-out" (i.e. measure performance among hospitals is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made) and the two new criteria that CMS proposes for determining "topped-out" status.

CMS also proposes to adopt one new measure for the Hospital OQR Program for the CY 2017 payment determination and subsequent years: OP-32: Facility Seven-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy.

CMS is considering expanding its current measure domains of process of care, imaging efficiency patterns, care transitions, emergency department throughput efficiency, and the use of health information technology. CMS is also exploring measures in the following areas: electronic clinical

quality, partial hospitalization, behavioral health, and measures that align with the National Quality Strategy and CMS Quality Strategy domains.

21. Ambulatory Surgical Center Quality Reporting (ASCQR) Program Updates

For CY 2015, CMS proposes to adopt the same criteria for determining when a measure is "topped-out" under the ASCQR Program as CMS proposes for the OQR Program.

For the CY 2017 payment determination and subsequent years, CMS proposes to adopt one new measure for the ASCQR Program: OP-32: Facility Seven-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy.

CMS is considering future ASCQR Program measures in the following measure domains: making care safer, strengthening person and family engagement, promoting effective communication and coordination of care, promoting effective prevention and treatment, working with communities to promote best practices of healthy living, and making care affordable.

22. Proposed Revision of the Requirements for Physician Certification of Hospital Inpatient Services Other Than Psychiatric Inpatient Services

In the FY 2014 IPPS proposed rule, CMS discussed the statutory requirement for certification of hospital inpatient services for payment under Medicare Part A other than psychiatric inpatient services. The certification requirement, found in SSA § 1814(a)(3), provides that Medicare Part A payment will only be made for such services "which are furnished over a period of time, [if] a physician certifies that such services are required to be given on an inpatient basis." CMS disagrees with commenters' assertion that the only possible interpretation of the statute is that the requirement for physician certification only applies to long-stay cases.

CMS continues to believe that the inpatient admission order is necessary for all inpatient admissions but also proposes to require such orders as a condition of payment based upon CMS's general rulemaking authority under SSA § 1871. In addition, CMS proposes to change its interpretation of SSA § 1814(a)(3) of the Act to require a physician certification only for long-stay cases and outlier cases. The SSA specifically requires that certification must occur no later than the 20th day and the regulations also specify that the physician certification for cost outlier cases occur no later than 20 days into the hospital stay. CMS is not proposing to change these requirements. CMS believes that, for non-outlier cases, 20 days is also an appropriate minimum threshold for the physician certification. CMS proposes to define long-stay cases as cases with stays of 20 days or longer.