Hospital Regulatory Update

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The Hospital Outpatient Prospective Payment System (OPPS) is not intended to be a fee schedule, in which separate payment is made for each coded line item. Instead, the OPPS is currently a prospective payment system that packages some items and services, but not others. CMS' overarching goal is to make payments for all services covered under the OPPS more consistent with those of a prospective payment system and less like those of a per-service fee schedule.

In CY 2017, outpatient hospital payment rates will increase by 1.7 percent and CMS will continue the statutory 2.0 percentage point reduction in payments for hospitals that fail to meet the hospital Outpatient Quality Reporting Program requirements. The CY 2016 conversion factor of $73.725 increases to $75.001 for CY 2017, but for hospitals that fail to meet the OQR (Outpatient Quality Reporting) requirements, the conversion factor will drop to $73.411. CMS will once again continue the policy of providing additional payments to the 11 designated cancer hospitals so that the hospital's payment-to-cost ratio, with the adjustment, is equal to the weighted average for the other OPPS hospitals. In addition, outlier payments will be triggered when the hospital's cost for furnishing a service exceeds two thresholds:

- Multiplier threshold: The cost must be at least 1.75 times the Ambulatory Payment Classification (APC) payment amount (no change from CY 2016); and
- Fixed-dollar threshold: The cost must also exceed the APC payment amount by at least $3,825; up from $3,250 last year.

Off-Campus Provider-Based Departments

CMS finalized policies to implement Section 603 of the Bipartisan Budget Act of 2015, which requires that certain items and services furnished by specific off-campus hospital outpatient departments will no longer be paid under the OPPS reimbursement mechanism beginning Jan. 1, 2017. Currently, Medicare pays for the same services at a higher rate if those services are provided in a hospital outpatient department rather than a physician's office. This payment differential has provided an incentive for hospitals to acquire physician offices in order to receive the higher rates. This acquisition trend and difference in payment has been highlighted as a long-standing issue of concern by Congress, the Medicare Payment Advisory Commission, and the Department of Health and Human Services Office of Inspector General (OIG). This difference in payment also increases costs for the Medicare program and raises the cost-sharing liability for beneficiaries.

Therefore, CMS is issuing an interim final rule with comment period (IFC) in conjunction with the OPPS final rule to establish new payment rates under the Medicare Physician Fee Schedule (MPFS) for items and services provided by certain off-campus provider-based departments (PBDs) in CY 2017. These new interim final rates adopted in the IFC will permit hospitals to be paid for furnishing items and services that may no longer be paid under the OPPS, and CMS believes this will reduce incentives for hospitals to acquire independent physician practices and convert them into more highly paid outpatient facilities. Physicians furnishing professional services in this setting will continue to be paid on the CMS1500 claim form and will be paid at the facility rate under the MPFS, in the same manner as all physicians practicing in an outpatient facility setting.

Hospitals will be paid under the MPFS at these newly established MPFS rates for non-excepted items and services, which will be billed on the UB04 claim (institutional claim) with a new claim line modifier:

- **Modifier PN**: Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital.

CMS states that non-excepted off-campus PBDs must report **modifier PN** on each UB04 claim line to indicate a non-excepted item or service. *All* non-excepted items and services billed by a hospital on an institutional claim with **modifier PN** will be paid under the MPFS at the rate established in this final rule. For CY 2017, the payment rate for these services will generally be 50 percent of the OPPS rate (with limited exceptions, such as separately payable drugs). Other OPPS policies, such as packaging of integral services, will continue to apply. CMS continues to seek comments on these new payment mechanisms and payment rates, and will make adjustments as necessary through future rulemaking.

CMS also finalized several policies regarding which off-campus PBDs and which items and services are "excepted" from the payment changes, and will therefore continue to be paid under OPPS

reimbursement. Excepted items and services furnished after Jan. 1, 2017, include:

- Services rendered by a dedicated emergency department;
- Items and services performed in an off-campus PBD that was billing for covered outpatient department services furnished prior to Nov. 2, 2015, and has not impermissibly relocated or changed ownership; or
- Services performed in a PBD that is "on the campus" (within 250 yards) of the hospital or a remote location of the hospital.

With respect to the relocation of an excepted off-campus PBD, CMS finalized the proposal that items and services must continue to be furnished and billed at the same physical address of the off-campus PBD to be considered excepted from Section 603 requirements. The final relocation policy includes a notable change from the proposed rule to allow these off-campus PBDs to relocate temporarily or permanently without loss of excepted status due to extraordinary circumstances outside the hospital's control, such as natural disasters. However, these exceptions for extraordinary circumstances will be reviewed by the CMS Regional Office and are expected to be rare and unusual.

In the CY 2017 OPPS proposed rule, CMS noted that it had received questions from some hospitals regarding whether an excepted off-campus PBD could expand the number or type of services the department furnished and still maintain excepted status. In response to public comments regarding the expansion of services performed in an excepted off-campus PBD, CMS is not finalizing its original proposal. Instead, CMS will monitor the expansion of clinical service lines by off-campus PBDs and continue to consider whether a potential limitation of service line expansion should be adopted in the future.

It is important to remember that the site-neutral rates only apply to facilities that began billing Medicare after Nov. 2, 2015. For those off-campus provider-based departments that were billing Medicare prior to this date, CMS will continue to require the following modifier on all excepted services:

- **Modifier PO**: Excepted service provided at an off-campus, outpatient, provider-based department of a hospital.

As a result, hospitals will append either the **PN** or **PO modifier** to every code for all outpatient hospital services furnished in an off-campus PBD of the hospital. These modifiers should not be used on services performed at remote locations of the hospital, satellite facilities of the hospital, or emergency departments. A remote location is defined as "a facility or an organization that is either created by, or acquired by, a hospital that is a main provider for the purpose of furnishing inpatient hospital services under the name, ownership, and financial and administrative control of the main provider." CMS states that questions about whether a particular location requires the reporting of these modifiers should be referred to CMS Regional Offices.

Packaged Services

The OPPS currently packages many categories of items and services that are typically provided as part of the primary hospital outpatient service. According to CMS, packaging encourages hospital efficiency, flexibility, and long-term cost containment, as well as promoting the stability of payment for services over time. For CY 2017, CMS will continue to refine packaging policies under the OPPS. Updates to packaging include:

- CMS finalized its proposal to align the packaging logic for all of the conditionally packaged services so that packaging occurs at the claim level, rather than date of service. According to CMS, this promotes consistency and ensures that items and services provided during a hospital stay are packaged even when the care spans more than a single service date.
- CMS previously adopted a policy to exclude molecular pathology tests from the laboratory packaging policy because these tests may have a different pattern of clinical use than more common and routine laboratory tests. As part of this final rule, CMS finalized the proposal to expand this laboratory test packaging exclusion to advanced diagnostic laboratory tests (ADLTs) that meet the same criteria.
- In CY 2014, CMS implemented **modifier L1** to allow for separate payment of laboratory tests when these tests were the only services on the claim or when the laboratory tests were unrelated to the other services on the claim. For CY 2017, CMS will discontinue separate payment for unrelated laboratory tests, and as a result the following modifier will be discontinued:
  - **Modifer L1**: Provider attestation that the hospital laboratory test(s) is not packaged under the hospital OPPS.

Comprehensive APCs

A comprehensive APC (C-APC), by definition, will provide a single payment that includes the primary service and all adjunct services performed to support the delivery of the primary service. For services that trigger a comprehensive APC payment, the comprehensive APC will treat all individually reported codes on the claim as representing components of the comprehensive service, resulting in a single prospective payment for the comprehensive service. This means that hospitals will continue to report procedure codes for all services performed, on one claim submission regardless of service date, and will receive a single payment for the total service and collect a single beneficiary copayment for the procedure and related services and supplies.

Effective Jan. 1, 2015, CMS implemented C-APCs for single fraction stereotactic radiosurgery (SRS, procedure codes **77371** and **77372**) and intraoperative radiation therapy (IORT), although CMS has reassigned intraoperative radiation therapy codes **77424** and **77425** from a breast surgery C-APC to the Level 7 Radiation

Therapy C-APC. Table 4, right, identifies brachytherapy catheter or needle insertion codes and their related procedures that are designated as C-APCs effective Jan. 1, 2017.

CMS finalized a proposal to create 25 additional C-APCs, bringing the total to 62; most of these represent major surgical procedures, but one new C-APC involves allogeneic hematopoietic stem cell transplantation. Allogeneic hematopoietic stem cell transplantation (HSCT) involves the intravenous infusion of hematopoietic stem cells derived from the bone marrow, umbilical cord blood, or peripheral blood of a donor to a recipient. As provided in the Medicare Claims Processing Manual, donor acquisition charges for allogeneic HSCT include charges for the costs of several services. These services include, but are not necessarily limited to:

- National Marrow Donor Program fees
- Tissue typing of donor and recipient
- Donor evaluation
- Physician pre-procedure donor evaluation services
- Costs associated with the collection procedure (for example, general routine and special care services, procedure/operating room and other ancillary services, apheresis services, among others)
- Post-operative and post-procedure evaluation of donor
- The preparation and processing of stem cells.

When the allogeneic stem cell transplant occurs in the hospital outpatient setting, providers are instructed to report stem cell donor acquisition charges for allogeneic HSCT separately in Field 42 on Form CMS-1450 (or UB-04) by using revenue code **0819** (Organ Acquisition: Other Donor). Revenue code **0819** charges should include all services required to acquire hematopoietic stem cells from a donor, as defined earlier, and should be reported on the same date of service as the transplant procedure in order to be appropriately packaged for payment purposes.

Based on current analysis of several longstanding issues and stakeholder input, CMS proposed to create a new **C-APC 5244** (Level 4 Blood Product Exchange and Related Services) and to assign procedures described by CPT code **38240** (hematopoietic progenitor cell [HPC]; allogeneic transplantation per donor) to this C-APC. The creation of a new C-APC for allogeneic HSCT would allow for the costs for all covered outpatient services, including donor acquisition services, listed on the claim to be packaged into the C-APC payment rate. CMS will analyze these costs using its comprehensive cost accounting methodology to establish future C-APC payment rates.

After consideration of the public comments received, CMS **established C-APC 5244** (Level 4 Blood Product Exchange and Related Services), with the modification to exclude claims that do not include donor acquisition costs reported with revenue code

Table 4. Brachytherapy Catheter or Needle Insertion Codes and Related Procedures Designated as C-APCs, Effective Jan. 1, 2017

2017 C-APC	CODES ASSIGNED TO APC
5091	**19499**: Unlisted breast procedure
5092	**19298**: Breast brachytherapy button & tube catheter placement
5093	**19296**: Breast brachytherapy balloon catheter placement
5113	**20555**: Placement of needles/catheters into muscle and/or soft tissue for subsequent interstitial radioelement application
5153	**31643**: Diagnostic bronchoscope, catheter placement
5165	**41019**: Placement of needles/catheters into head and/or neck region for radioelement application
5302	**43241**: Upper GI endoscopy, catheter placement
5341	**55920**: Placement of needles/catheters into pelvic organs and/or genitalia (except prostate) for radioelement application
5414	**57155**: Insertion of uterine tandem and/or vaginal ovoids **58346**: Insertion of Heyman capsules for clinical brachytherapy

Table 5. CY 2017 Radiation Therapy APCs & Final APC Code Assignments

2017 C-APC	TITLE	CODES ASSIGNED TO APC
5621	Level 1 Radiation Therapy	77401, 77402, 77407, 77789, 77799
5622	Level 2 Radiation Therapy	0394T, 77412, 77600, 77750, 77767, 77768
5623	Level 3 Radiation Therapy	77385, 77386, **77422**, 77423, 77470, 77520, 77610, 77615, 77620, 77761, 77762
5624	Level 4 Radiation Therapy	0395T, 77605, 77763, 77770, 77771, 77772, 77778
5625	Level 5 Radiation Therapy	77522, 77523, 77525
5626	Level 6 Radiation Therapy	77373
5627	Level 7 Radiation Therapy	77371, 77372, **77424**, **77425**

0819 from rate setting. CMS also established a final payment rate for new **C-APC 5244** of $27,752 for CY 2017.

Pain Management

Physicians and other healthcare providers have expressed concern that patient safety questions about pain management in the Hospital Value-Based Purchasing program may influence prescribing practices. While there is no empirical evidence of such an effect, CMS finalized the removal of the pain management dimension of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey to eliminate any financial pressure clinicians may feel to overprescribe medications. CMS will continue the development of alternative questions related to provider communications and pain, and will solicit comments in future rulemaking.

Radiation Oncology Services

Section 1833(t)(2)(A) of the Social Security Act requires CMS to develop a classification system for covered outpatient department services. In accordance with these provisions, CMS developed a grouping classification system, referred to as Ambulatory Payment Classifications (APCs). The APCs are organized so that each group is homogenous, both clinically and in terms of resource use. As part of its continuing review of the structure of APC families, CMS finalized the proposal to reduce the number of clinical APCs for Therapeutic Radiation Treatment Preparation from 4 levels to 3 levels:

- **APC 5611**: Level 1 Therapeutic Radiation Treatment Preparation
- **APC 5612**: Level 2 Therapeutic Radiation Treatment Preparation
- **APC 5613**: Level 3 Therapeutic Radiation Treatment Preparation.

Essentially, CMS consolidated prior Level 1 & Level 2 procedure codes into Clinical **APC 5611** (Level 1), with the exception of code **77306** (teletherapy isodose plan; simple), which remains in **APC 5612**. All codes previously listed in Level 3 have been assigned to Level 2, and all codes previously listed in Level 4 are now included in Level 3. With regard to reimbursement, the following procedures that will now be reimbursed at the Level 1 payment are expected to decrease approximately 29.5 percent:

- **77280**: Therapeutic radiology simulation-aided field setting; simple
- **77333**: Treatment devices, design and construction; intermediate.
- **77370**: Special medical radiation physics consultation.

In addition to these APC changes, code **77422** and intraoperative radiation treatment delivery codes **77424** and **77425** were also reassigned to different APC categories (see bold text in Table 5, above).

Once again, CMS will continue paying for low-dose rate prostate brachytherapy using composite **APC 8001**. In order for hospitals to receive the higher composite APC reimbursement, both code **77778** (Interstitial radiation source application, complex, includes supervision, handling, loading of radiation source, when performed) and **55875** (Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy) must be billed on the same claim. The Medicare Prescription Drug Improvement and Modernization Act of 2003 requires CMS to continue to separate payment for brachytherapy sources in CY 2017 and subsequent years. These sources

are reimbursed on a prospective basis, with 2017 payment rates set using the 2015 geometric mean unit codes for each source. CMS assigned new **status indicator E2** (Items and services for which pricing information and claims data are not available) to HCPCS code **C2644** (Brachytherapy source, cesium-131 chloride solution, per millicurie) because this code was not reported on CY 2015 claims.

Medical Oncology & Hematology Services

CMS assigned new CY 2017 CPT code **96377** (Application of on-body injector [includes cannula insertion] for timed subcutaneous injection) to **status indicator N** (Items and Services Packaged into APC Rates) to indicate that the service is paid under the OPPS; however, its payment is packaged into the payment for other services. Some commenters disagreed with the proposed status indicator assignment of N for code **96377**, and indicated that this is a primary service, not an add-on procedure, that represents a complete and unique drug administration service that a hospital performs for the subcutaneous administration of Neulasta® with the on-body injector. The commenters stated that the service is similar to the drug administration service described by procedure code **96372** (Therapeutic, prophylactic, or diagnostic injection [specify substance or drug]; subcutaneous or intramuscular), which is assigned to **APC 5692** (Level 2 Drug Administration) with a proposed payment rate of approximately $53. CMS stated they do not believe that the resources necessary to deliver the Neulasta service warrants separate payment under the OPPS. Because payment for CPT code **96377** will be packaged, the payment for use of the on-body injector will be included in the payment for the primary service (for example, chemotherapy administration or a clinic visit) that is reported on the same service date as code **96377**.

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Table 6. Pass-Through Status for Drugs & Biologicals that will Expire Dec. 31, 2016

CY 2017 HCPCS CODE	CY 2017 LONG DESCRIPTOR	FINAL CY 2017 SI	FINAL CY 2017 APC
C9497	Loxapine, inhalation powder, 10 mg	K	**9497**
J1322	Injection, elosulfase alfa, 1mg	K	**1480**
J1439	Injection, ferric carboxymaltose, 1 mg	N	**N/A**
J1447	Injection, TBO-Filgrastim, 1 microgram	N	**N/A**
J3145	Injection, testosterone undecanoate, 1 mg	N	**N/A**
J3380	Injection, vedolizumab, 1 mg	K	**1489**
J7181	Injection, factor XIII a-subunit, (recombinant), per IU	N	**N/A**
J7200	Factor IX (antihemophilic factor, recombinant), Rixubus, per IU	N	**N/A**
J7201	Injection, factor IX, fc fusion protein (recombinant), per IU	N	**N/A**
J7205	Injection, factor VIII fc fusion (recombinant), per IU	K	**1656**
J7508	Tacrolimus, extended release, (Astragraf xl), oral, 0.1 mg	N	**N/A**
J9301	Injection, obinutuzumab, 10 mg	N	**N/A**
J9308	Injection, ramucirumab, 5 mg	K	**1488**
J9371	Injection, Vincristine Sulfate Liposome, 1 mg	K	**1466**
Q4121	Theraskin, per square centimeter	N	**N/A**

Table 7. Drugs & Biologicals With Pass-Through Status in CY 2017

CY 2016 HCPCS CODE	CY 2017 HCPCS CODE	CY 2017 LONG DESCRIPTOR	CY 2017 SI	CY 2017 APC
A9586	**A9586**	Florbetapir f18, diagnostic, per study dose, up to 10 mci	G	**1664**
N/A	**A9588**	Fluciclovine f-18, diagnostic, 0.1 mCi	G	**9052**
N/A	**A9587**	Gallium Ga-68, dotatate, diagnostic, 1 mCi	G	**9056**
N/A	**C9140**	Injection, Factor VIII (antihemophilic factor, recombinant) (Afstyla), 1 IU	G	**9043**
C9137	**J7207**	Injection, Factor VIII (antihemophilic factor, recombinant) PEGylated, 1 IU	G	**1844**
C9138	**J7209**	Injection, Factor VIII (antihemophilic factor, recombinant) (Nuwiq), per IU	G	**1846**
C9139	**J7202**	Injection, Factor IX, albumin fusion protein (recombinant), Idelvion, 1 IU	G	**9171**
C9349	**Q4172**	PuraPly, and PuraPly Antimicrobial, any type, per sq cm	G	**1657**
C9447	**C9447**	Injection, phenylephrine and ketorolac, 4 ml vial	G	**1663**
C9460	**C9460**	Injection, cangrelor, 1 mg	G	**9460**
C9461	**A9515**	Choline C 11, diagnostic, per study dose	G	**9461**
C9470	**J1942**	Injection, aripiprazole lauroxil, 1 mg	G	**9470**
C9471	**J7322**	Hyaluronan or derivative, Hymovis, for intra-articular injection, 1 mg	G	**9471**
C9472	**J9325**	Injection, talimogene laherparepvec, 1 million plaque forming units (PFU)	G	**9472**
C9473	**J2182**	Injection, mepolizumab, 1 mg	G	**9473**
C9474	**J9205**	Injection, irinotecan liposome, 1 mg	G	**9474**
C9475	**J9295**	Injection, necitumumab, 1 mg	G	**9475**
C9476	**J9145**	Injection, daratumumab, 10 mg	G	**9476**
C9477	**J9176**	Injection, elotuzumab, 1 mg	G	**9477**
C9478	**J2840**	Injection, sebelipase alfa, 1 mg	G	**9478**
C9479	**J7342**	Instillation, ciprofloxacin, otic suspension, 6 mg	G	**9479**
C9480	**J9352**	Injection, trabectedin, 0.1 mg	G	**9480**
C9481	**J2786**	Injection, reslizumab, 1 mg	G	**9481**
C9482	**C9482**	Injection, sotalol hydrochloride, 1 mg	G	**9482**
C9483	**C9483**	Injection, atezolizumab, 10 mg	G	**9483**
N/A	**J0570**	Buprenorphine implant, 74.2 mg	G	**9058**
J0596	**J0596**	Injection, c-1 esterase inhibitor (human), Ruconest, 10 units	G	**9445**

Table 7. Drugs & Biologicals With Pass-Through Status in CY 2017 (*continued*)

CY 2016 HCPCS CODE	CY 2017 HCPCS CODE	CY 2017 LONG DESCRIPTOR	CY 2017 SI	CY 2017 APC
J0695	**J0695**	Injection, ceftolozane 50 mg and tazobactam 25 mg	G	**9452**
J0875	**J0875**	Injection, dalbavancin, 5 mg	G	**1823**
J1833	**J1833**	Injection, isavuconazonium sulfate, 1 mg	G	**9456**
J2407	**J2407**	Injection, oritavancin, 10 mg	G	**1660**
J2502	**J2502**	Injection, pasireotide long acting, 1 mg	G	**9454**
J2547	**J2547**	Injection, peramivir, 1 mg	G	**9451**
J2860	**J2860**	Injection, siltuximab, 10 mg	G	**9455**
J3090	**J3090**	Injection, tedizolid phosphate, 1 mg	G	**1662**
N/A	**J7179**	Injection, von Willebrand factor (recombinant), (Vonvendi), 1 IU vwf:rco	G	**9059**
J7313	**J7313**	Injection, fluocinolone acetonide intravitreal implant, 0.01 mg	G	**9450**
J7503	**J7503**	Tacrolimus, extended release, (Envarsus xr), oral, 0.25 mg	G	**1845**
J8655	**J8655**	Netupitant (300mg) and palonosetron (0.5 mg)	G	**9448**
J9032	**J9032**	Injection, belinostat, 10 mg	G	**1658**
J9039	**J9039**	Injection, blinatumomab, 1 mcg	G	**9449**
J9271	**J9271**	Injection, pembrolizumab, 1 mg	G	**1490**
J9299	**J9299**	Injection, nivolumab, 1 mg	G	**9453**
Q5101	**Q5101**	Injection, Filgrastim (G-CSF), Biosimilar, 1 microgram	G	**1822**
Q9950	**Q9950**	Injection, sulfur hexafluoride lipid microsphere, per ml	G	**9457**
C9459	**Q9982**	Flutemetamol F18, diagnostic, per study dose, up to 5 mci	G	**9459**
C9458	**Q9983**	Florbetaben F18, diagnostic, per study dose, up to 8.1 mci	G	**9458**

(*continued from page 25*)

Blood & Blood Products

In the CY 2017 OPPS proposed rule, CMS recommended continuing to establish payment rates for blood and blood products using the current blood-specific cost-to-charge ratio (CCR) methodology. After consideration of the public comments received, CMS finalized this proposal.

As discussed in the CY 2016 OPPS final rule, CMS is in the process of examining the current set of HCPCS P-codes for blood products. Because these codes were created many years ago, CMS is considering whether this code set would benefit from some code descriptor revisions, updating, and/or consolidation to make these codes properly reflect current product descriptions and utilization while minimizing redundancy and eliminating potentially outdated descriptors.

In the CY 2017 OPPS proposed rule, public comments were requested and CMS asked the blood product stakeholder community whether the current blood product HCPCS P-code descriptors with the associated granularity best describe the state of the current technology for blood products that hospitals currently provide to hospital outpatients. A number of detailed responses were received, and these comments will be taken into consideration in the development of proposals to update codes that describe blood products.

Pass-Through Drug Payments

Section 1833 of the Social Security Act permits CMS to make pass-through payments for a period of at least two, but not more than three, years after the product's first payment as a hospital outpatient service under Medicare Part B. The longstanding practice has been to provide pass-through payment for a period of two to three years, with expiration of pass through status proposed and finalized through the annual rulemaking process. CMS currently accepts applications for pass-through status on a quarterly basis, but this status expires on an annual basis. Beginning in CY 2017, pass-through status will expire on a quarterly basis so that the biological will receive pass-through status for as close to three full years as possible.

CMS included a list of the drugs for which pass-through status will expire on Dec. 31, 2016, in the final rule (see Table 6, page 25).

Payment for drugs and biologicals with pass-through status under the OPPS in CY 2017 will be made at the rate of ASP+6 percent. However, hospitals will actually receive no extra payment for most of these pass-through drugs because they would receive the difference between the regular OPPS drug payment and the pass-through payment. At this time, both of these payment amounts are ASP+6 percent, so the difference is $0. Hospitals will receive payment for pass-through drugs that are classified as "policy-packaged," such as diagnostic radiopharmaceuticals, contrast agents, and anesthesia drugs, since the regular OPPS drug payment for these biologicals is $0. The drugs and biological listed in Table 7, pages 26-27, will continue or have been granted pass-through status for CY 2017.

Drugs and therapeutic radiopharmaceuticals without pass-through status are paid separately only if the average per diem cost is greater than that year's packaging threshold. For CY 2017, the threshold is $110, up from $100 in CY 2016. CMS adds that packaging costs into a single aggregate payment for a service, procedure, or episode-of-care is a fundamental principle that distinguishes a prospective payment system from a fee schedule. CMS is also continuing its policy of making a single packaging decision for all dosages of a drug that is available in multiple dosages that have separate HCPCS codes.

Other Provisions

In addition to the major provisions listed above, the 2017 OPPS final rule addresses restructuring of the imaging APCs, the Ambulatory Surgical Center (ASC) payment update, the hospital Value-Based Purchasing Program, the hospital Outpatient Quality Reporting (OQR) Program, Medicare Conditions of Participation for Organ Transplant programs, and the Electronic Health Record (EHR) Incentive Program. OI