INPATIENT ONLY LIST

Advisory Panel on Hospital Outpatient Payment

Presented by The Provider Roundtable

August 31, 2020

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The Provider Roundtable (PRT)

- PRT members represent 14 hospitals and/or health systems representing patients from 20 states across the country
- As provider employees, we have no financial relationship to report related to this proposal

Affected CPTs and APCs

- HCPCS Codes: Specific HCPCS codes currently assigned status indicator “C”
- APCs: Musculoskeletal APCs and other APCs or C-APCs that may be assigned but this is to be determined by CMS

Description of The Issue

- In the CY 2021 OPPS Proposed Rule CMS proposes to eliminate the inpatient-only list over time
- The PRT is pleased to see CMS' proposal as it reflects our long-standing request to the agency that this list be eliminated so that hospitals may be paid when these types of procedures are safely and appropriately provided to Medicare beneficiaries as outpatients.
- CMS also proposes to remove approximately 300 musculoskeletal-related services and assign them to clinical APCs for CY 2021. We have not reviewed the proposed APC assignments but anticipate doing so, given the very limited outpatient claims data CMS had for rate-setting. To the extent we are able, we will use internal cost data to review proposed APC assignments and provide feedback to CMS in our written comment letter.
- CMS is also seeking input on whether additional codes should be removed from the inpatient only list for CY 2021

Recommendation

- The PRT recommends the HOP Panel request CMS to remove the following additional HCPCS codes from the inpatient only list for CY 2021.

35372	Thromboendartere ctomy, including patch graft, if performed; deep (profunda) femoral
35721	Exploration (not followed by surgical repair), with or without lysis of artery; femoral artery
35800	Exploration for post op hemorrhage, thrombosis or infection; neck
37182	TIPS procedure
37617	Ligation, major artery; abdomen
38562	Limited lymphadenectomy for staging (separate procedure); pelvic and para-aortic
43840	Gastrorrhaphy, suture of perforated duodenal or gastric ulcer, wound, or injury
44300	Open jejunostomy following a diagnostic laparoscopy
44314	Revision of ileostomy; complicated (reconstruction indepth) (separate procedure)
44345	Revision of colostomy; complicated (reconstruction indepth) (separate procedure)
44346	Revision of colostomy; with repair of paracolostomy hernia (separate procedure)
44602	Suture of small intestine accidental laceration
49010	Exploration, retroperitoneal area with or without biopsy(s) (separate procedure)
49255	Omentectomy, epiploectomy, resection of omentum
51840	Anterior vesicourethropexy , or urethropexy (eg, MarshallMarchetti-Krantz, Burch); simple
56630	Vulvectomy, radical, partial;
61624	Transcatheter permanent occlusion or embolization, percutaneous, any method; central nervous system

- The PRT believes it is most logical to assign C-APCs to procedures removed from the inpatient only list.
- We also recommend that CMS review 012x Part B claims for these procedures as a means to estimate cost in order to make appropriate APC assignments

Rationale for Recommendation

- The codes we are recommending have all been recommended previously, and have all likely been evaluated by CMS to some extent in the past. Therefore, CMS should have some historical analyses and data to assist with rate-setting and appropriate APC assignment.
- CMS' proposal to eliminate the inpatient only list is consistent with what stakeholders have been asking for many years
- Since physicians order procedures (not hospitals), but do not have a similar restrictive list, it makes no sense that hospitals should have a restrictive list

Expected Outcomes

- Hospitals will be able to receive reimbursement for services that clinicians determine are safe and appropriate for specific Medicare beneficiaries to receive in the outpatient setting.

Summary and Final Recommendation

- The PRT requests the HOP Panel recommend that CMS:
  - *Remove the specific CPT codes provided in this presentation in the table on slide 6 from the inpatient only list.*
  - *Look to assign C-APCs to procedures removed from the inpatient only list*
  - *Review and use to the extent appropriate, 012x Part B claims data as a means to estimate cost for these procedures to inform appropriate APC assignments*