Abbott’s vascular division is pleased to provide you with this summary of the Medicare Hospital Outpatient Prospective Payment System (OPPS) Update for Calendar Year (CY) 2017. The information in this document is effective January 1, 2017 to December 31, 2017.

**OPPS HIGHLIGHTS**

**CY 2017 Payment Update**

The Centers for Medicare & Medicaid Services (CMS) released the CY 2017 final rule for Medicare’s hospital outpatient prospective payment system (OPPS) and ambulatory surgical center (ASC) payment system on November 1, 2016. The OPPS fee schedule increase of 1.65 percent will be applied to the conversion factor. The OPPS payments are estimated to increase by approximately 1.7 percent compared to CY 2016 payments. For CY 2017, the conversion factor is set at $75.001 for hospitals meeting the requirements of the quality reporting program. A conversion factor reduced by 2 percent, $73.411, will be used for hospitals that fail to meet the quality requirements.

The simple average (non-weighted) changes for procedures that may use Abbott’s vascular products are presented below.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Embolization</td>
<td>+2%</td>
</tr>
<tr>
<td>Angioplasty</td>
<td>+4%</td>
</tr>
<tr>
<td>Stenting</td>
<td>+2%</td>
</tr>
</tbody>
</table>

Peripheral arterial interventional procedure payment rate changes:

Coronary arterial diagnostic and interventional procedure payment rate changes:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bare metal stenting</td>
<td>+2%</td>
</tr>
<tr>
<td>Drug-eluting stenting</td>
<td>+2%</td>
</tr>
<tr>
<td>Diagnostic cardiac catheterization</td>
<td>+9%</td>
</tr>
</tbody>
</table>

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1 Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Short Inpatient Hospital Stays; Transition for Certain Medicare-Dependent, Small Rural Hospitals under the Hospital Inpatient Prospective Payment System; Provider Administrative Appeals and Judicial Review; 42 CFR Parts 405, 410, 412, 413, 416, and 419; Accessed November 10, 2016 at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1656-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending

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**Updates to the Comprehensive APC Policy**

For CY 2017, CMS continues the Comprehensive APC (C-APC) policies established in CY 2015. Under the policy, CMS designates an HCPCS code as a primary service assigned to a C-APC and makes payment for all other items and services reported on the claim as being integral, ancillary, supportive, depending, and adjunct to the primary service. Most coronary and endovascular procedures qualify for these C-APC payments. For CY 2017, CMS continues those previously established and adds 25 new C-APCs. Among these newly created C-APCs are diagnostic catheterization and angiographies, resulting in a new level and re-leveling of existing procedures within the Endovascular Procedures family.

The following four primary procedure C-APCs in the VASCX Clinical Family will be used in 2017:

<table>
<thead>
<tr>
<th>2017 C-APC</th>
<th>Description</th>
<th>HCPCS Codes for Primary Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>5191</td>
<td>Level 1 Endovascular Procedures</td>
<td>93451, 93452, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93530, 93531, 93532, 93533</td>
</tr>
<tr>
<td>5192</td>
<td>Level 2 Endovascular Procedures</td>
<td>0338T, 0339T, 36902, 36904, 37183, 37220, 37224, 37246, 37248, 92920, 92986</td>
</tr>
<tr>
<td>5193</td>
<td>Level 3 Endovascular Procedures</td>
<td>0234T, 0236T, 0237T, 36903, 36905, 37221, 37225, 37226, 37228, 3726, 37238, 37241, 37242, 37243, 37244, 61623, 61626, 92924, 92928, 92937, 92941, 92943, 92987, 92990, 92997, C6900, C6904</td>
</tr>
<tr>
<td>5194</td>
<td>Level 4 Endovascular Procedures</td>
<td>0238T, 0387T, 36906, 37227, 37229, 37230, 37231, 92933, 93580, 93581, 93582, 93590, 93591, C9602, C9606, C6907</td>
</tr>
</tbody>
</table>

**Site Neutral Payments**

CMS is implementing Section 603 of the Bipartisan Budget Act of 2015, which requires that certain items and services provided by certain off-campus provider-based departments (PBDs) will not be covered and paid through the OPPS. The majority of these services will be paid under the Medicare Physician Fee Schedule (MPFS).

Site-of-service payment rates for PBDs were established under the MPFS through an interim final rule. These must be reported on the institutional claim form, identified with new claims line modifier “PN.” In general, the payment rate for non-excepted services provided by PBDs is 50 percent of the OPPS rate.

**Packaged Services**

Integral, ancillary, supportive, dependent, or adjunctive services will be packaged into primary services at the claim level as opposed to date of service. This will ensure that hospital stays spanning more than one day are still packaged in line with OPPS policies.
Device-Intensive Procedures

Procedures are defined as “device-intensive” when greater than 40 percent of the APC payment amount is associated with the cost of devices (the device offset). CMS is finalizing its proposal to change from calculating the device offset based on the APC and instead will calculate it at the HCPCS code level. This will result in procedures (instead of APCs) being defined as “device-intensive.”

In addition, the payment rate for device-intensive procedures mapped to an APC with less than 100 total claims will be based on the median cost instead of the geometric mean cost. This will limit inappropriate year-to-year payment fluctuations.

Updates to the Transitional Pass-Through Payment Policy

Transitional pass-through payments allow additional payment for new medical devices. CMS is finalizing two important changes to the pass-through policy. In CY 2016, CMS adopted a policy to evaluate device pass-through applications through the annual rule-making process in addition to quarterly subregulatory review process.

Three applications were submitted by the March 1, 2016 deadline, however none of these were approved for transitional pass-through payments.

- BioBag® (Larval Debridement Therapy in a Contained Dressing)
- Encore™ Suspension System
- Endophys Pressure Sensing System/Kit

Devices eligible for Transitional Pass-Through Payment in CY 2017:

- C2623 (Catheter, transluminal angioplasty, drug-coated, non-laser)
- C2613 (Lung biopsy plug with delivery system)
- C1822 (Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system)

Device with Transitional Pass-Through Payments expiring December 31, 2016:

- C2624 (Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components)
Hospital Outpatient Quality Reporting (OQR) Program

If outpatient hospital departments fail to meet requirements for the OQR, they are subject to a reduction of two percentage points to their fee schedule increase factor.

Starting with CY 2018 payment determination, CMS will publicly display measure data (on Hospital Compare or the CMS website).

CMS will add seven measures to the CY 2020 payment determination and subsequent years:

- OP-35: Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy
- OP-36: Hospital Visits after Hospital Outpatient Surgery
- OP-37a: Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) – About Facilities and Staff
- OP-37b: OAS CAHPS – Communication About Procedure
- OP-37c: OAS CAHPS – Preparation for Discharge and Recovery
- OP-37d: OAS CAHPS – Overall Rating of Facility
- OP-37e: OAS CAHPS – Recommendation of Facility
# Medicare 2017 Hospital Outpatient Reimbursement

<table>
<thead>
<tr>
<th>APC</th>
<th>Description</th>
<th>Final Rule Base Rate</th>
<th>APC</th>
<th>Description</th>
<th>Final Rule Base Rate</th>
<th>% Difference CY 2016 to CY 2017</th>
<th>$ Difference CY 2016 to CY 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>5188</td>
<td>Diagnostic Cardiac Catheterization</td>
<td>$2,549</td>
<td>5191</td>
<td>Level 1 Endovascular Procedures</td>
<td>$2,832</td>
<td>11%</td>
<td>$283</td>
</tr>
<tr>
<td>5191</td>
<td>Level 1 Endovascular Procedures</td>
<td>$4,592</td>
<td>5192</td>
<td>Level 2 Endovascular Procedures</td>
<td>$4,823</td>
<td>5%</td>
<td>$231</td>
</tr>
<tr>
<td>5192</td>
<td>Level 2 Endovascular Procedures</td>
<td>$9,542</td>
<td>5193</td>
<td>Level 3 Endovascular Procedures</td>
<td>$9,748</td>
<td>2%</td>
<td>$206</td>
</tr>
<tr>
<td>5193</td>
<td>Level 3 Endovascular Procedures</td>
<td>$14,612</td>
<td>5194</td>
<td>Level 4 Endovascular Procedures</td>
<td>$14,776</td>
<td>1%</td>
<td>$164</td>
</tr>
<tr>
<td>5571</td>
<td>Level 1 CT with Contrast and CT Angiography</td>
<td>$237</td>
<td>5571</td>
<td>Level 1 Diagnostic Radiology with Contrast</td>
<td>$265</td>
<td>12%</td>
<td>$28</td>
</tr>
</tbody>
</table>

Denotes Comprehensive APCs.
Please visit Abbott’s Vascular Reimbursement website at:

www.vascular.abbott/us/professional-resources/reimbursement.html

For questions regarding this Reimbursement Update and other questions regarding reimbursement for Abbott’s vascular products and related services, please contact:

Abbott’s Vascular Reimbursement Hotline

📞 800.354.9997
✉️ Questions@AskAbbottVascular.com

For questions regarding reimbursement for St. Jude Medical products and related services, please contact:

St. Jude Medical Reimbursement Hotline

📞 855.569.6430
✉️ hce@sjm.com

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