CY 2015 Medicare Outpatient Prospective Payment System (OPPS) Proposed Rule

Learn
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Lead

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CY 2015 OPPS Proposed Rule

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- **Comments on the proposed rule are due September 2, 2014 →** CMS will respond to comments in a final rule to be issued on or around November 1, 2014

Topics for Today's Teleconference

- Market Basket Update
- No Collapsing 5 ED E&M Codes into 1
- Collecting Data Re: Off-campus Provider-based Facilities
- New Packaging Policy
- Comprehensive APCs
- New and Revised CPT Codes – Interim HCPCS G-Codes
- Revised Physician Certification Requirements
- Inpatient-only List
- Cost Threshold for Skin Substitutes
- Pass-through Payments for Devices
- No Cost/Full Credit and Partial Credit Devices
- Pass-through Payments for Drugs & Biologicals
- Separately Payable Drugs/Biologicals Paid at ASP +6%
- Cancer Hospital Payments
- Payment for Partial Hospitalization (PHP) Services
- Overpayments Associated with MA and Part D Data
- OQR/ASC Quality Programs Update

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Topics for Today's Teleconference

Topic	FR Pages (July 14, 2014)
Market Basket Update	40962 – 40963
No Emergency Department Code Collapse	41008 – 41009
Collecting Data Re: Off-campus Provider-based Facilities	41013 – 41014
New Packaging Policy	40959 – 40961
Creation of New "Comprehensive APCs"	40940 – 40958
Wage Index Update	40963 - 40965
Outpatient Outlier	40970 – 40972
Revised Physician Certification Requirements	41056 – 41058

Topics for Today's Teleconference

Topic	FR Pages (July 14, 2014)
Inpatient-only List	41012 – 41013
Pass-through Payments for Devices	40989 – 40990
No Cost/Full Credit and Partial Credit Devices	40990 – 40991
Pass-through Payments for Drugs & Biologicals	40992 – 40994
Separately Payable Drugs/Biologicals Paid at ASP +6%	41003
Cancer Hospital Payments	40968 – 40969
Payment for Partial Hospitalization (PHP) Services	41009 – 41012
Overpayments Associated with MA and Part D Data	41058 – 41063
OQR/ASC Quality Programs Update	41032 – 41052

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Conversion Factor Update

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CY 2015 OPPS Conversion Factor Update

- Use IPPS market basket projected increase = 2.7 percent
  - Less 2 percent if hospital doesn't submit quality data
- Less productivity adjustment = 0.4 percent
- Less ACA reduction = 0.2 percent
- Aggregate OPPS "update" = 2.1 percent

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ED Visit Code Collapse?

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ED Visit Code Collapse? Deferred

- Last year, CMS collapsed clinic visit E/M codes
- Did NOT finalize proposal to collapse ED visit codes – said they would reconsider this year
- Deferred again: "We continue to believe that additional study is needed…We intend to further explore the issues…related to ED visits, including concerns about excessively costly patients, such as trauma patients."
- May make changes in future rulemaking

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Off-Campus Provider-Based Facilities – Data Collection

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Data Collection: Off-Campus Provider-Based Facilities

- Reference to MedPAC concerns about higher payments to hospital-based facilities than freestanding clinics
- Last year, asked for preference on how to collect info (claims-based approach v. cost report), and got no consensus
- Proposal: starting 1/1/15, use HCPCS modifier with every code for physician services and outpatient hospital services furnished in off-campus provider-based department, reported on:
  - CMS-1500 (for physician services)
  - UB-04 (CMS Form 1450) (for hospital outpatient services)

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Packaging

Proposed New Packaging Policies

- CMS proposes to expand packaging to 2 more categories of items and services:
  1. Ancillary Services (but only for APCs with proposed geometric mean cost ≤ $100)
  2. Prosthetic Supplies
- Why? To continue to make OPPS more like a prospective payment and less like a fee schedule

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Packaging Ancillary Services

- Proposed last year but was not finalized then
  - Concern that low volume but relatively costly ancillary services would be packaged into high volume but relatively inexpensive primary services
- Now proposing to package when:
  - Performed with another service (still separately paid when performed alone)
  - Ancillary service APC has proposed geometric mean cost ≤ $100

Note: once packaged, always packaged

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Packaging Ancillary Services, cont.

- Exclusions:
  - Preventive services (see Table 10)
  - Certain psychiatry and counseling-related services
  - Certain low cost drug administration services
- Status indicators?
  - Deleting SI “X”
  - Most will now go to SI “Q1” (STV-Packaged Codes)
  - Remaining, not conditionally packaged, go to SI “S” (Procedure or Service, Not Discounted When Multiple)

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Packaging Prosthetic Supplies

- Prosthetic supplies currently paid under DMEPOS Fee Schedule, even when provided in HOPD
- Proposal to package beginning CY 2015, because "all of the components are typically necessary for the performance of the system and the hospital typically purchases the system as a single unit"
- Replacement supplies provided later, still paid under DMEPOS Fee Schedule

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Comprehensive APCs

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Comprehensive APCs (C-APCs)

- Comprehensive APC = a primary service and all adjunctive services provided to support the delivery of the primary service
  - Paid with one single prospective payment anytime a primary procedure (SI = J1) appears on a claim
  - Other services conditionally packaged
- Finalized last year but implementation deferred
- Proposed again for CY 2015 with some changes
- CMS proposes to establish 28 comprehensive APCs

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C-APCs: Changes from Last Year

- Restructuring/consolidating some proposed C-APCs to improve resource & clinical homogeneity
- Package ALL add-on-codes (SI = “N”)
- ALL device-dependent procedures now included in this policy (not just a subset)
- 2 new C-APCs:
  - Single-session cranial stereotactic radiosurgery
  - Intraocular telescope implantation

C-APCs: Complexity Adjustment Changes

CY 2014	CY 2015
Comprehensive geometric mean cost >2x comprehensive geometric mean cost of single major claims reporting only primary service, AND	Violation of the 2x rule (i.e. comprehensive geometric mean cost of complex code combination exceeds comprehensive geometric mean cost of lowest significant HCPCS code assigned to the C-APC)
>100 claims/year reporting code combination, AND	≥ 25 claims reporting the code combination
Code combo = >5% of volume of all claims reporting primary service, AND	
No violation of “2 times” rule within receiving C-APC	

Note: if complexity adjustment, reassigned to higher level C-APC within same clinical family; if already in highest level C-APC within family, no complexity adjustment

C-APCs: Exclusions for CY 2015

Table 6 contains exclusions – NOT bundled into C-APC:

- Ambulance services
- Bracytherapy
- Diagnostic & mammography screenings
- PT, speech-language pathology, occupational therapy services
- Pass-through drugs, biologicals, and devices
- Preventive services (e.g., annual wellness visits)
- Self-administered drugs
- SI “F” (certain CRNA services, Hep B vaccines, corneal tissue acquisition)
- SI “L” (influenza and pneumococcal pneumonia vaccines)
- Certain Part B inpatient services

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New and Revised CPT Codes: Interim HCPCS G-Codes

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New and Revised CPT Codes: Use of New HCPCS G-Codes

- CMS proposes to modify current process for accepting comments on new and revised CPT codes (also in PFS proposed rule), effective 2016
- Why? Concern re: lack of opportunity for public comment prior to Jan. 1 implementation date
- Current process:
  - AMA publishes CPT codes in the fall, effective January 1
  - CMS assigns interim APCs and SIs, and opens public comment during OPPS final rule
  - CMS pays under interim designations for 1 year
  - Comments addressed in following year's final rule

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New and Revised CPT Codes, cont.

Proposed Revised Process:

- New/revised CPT codes received too late for inclusion in proposed rule:
  - Delay adoption of new codes
  - Create and use HCPCS G-codes that mirror the predecessor codes, and keep current APC and SI for one year
  - Include proposed assignment in following year's proposed rule
  - Administrative burden?

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New and Revised CPT Codes, cont.

Proposed Revised Process, cont.:

- "Wholly New Services":
  - Will "make every effort to work the AMA CPT Editorial Panel" to get the codes in time for the proposed rule
  - If not in time, will establish interim APC and SI for 1 year (i.e. follow current process)

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New and Revised CPT Codes, cont.

CMS specifically interested in your answers to:

- Is this proposal preferable to the current process?
- Better to move forward now or delay implementation of new policy beyond CY 2016?
- Alternatives to using HCPCS G-codes?
- Is the proposal appropriate re: wholly new services?
- How should CMS define new services?
- Any other classes of services (other than new services) that should remain on an interim final schedule?

Physician Certification

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Physician Certification

- **Physician order** → required for all inpatient admissions
  - Needed for the beneficiary to be considered an inpatient
  - Triggers the requirement for payment under Part A
  - CMS proposes to remove the physician order requirement as an element of certification. Instead, it will be required under its general rulemaking authority (Sec. 1871 of the SSA).
- CMS proposes to **only** require **physician certification** for long-stay cases (20 days or longer) and other outlier cases

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Physician Certification

- Physician certification required for Part A payment for inpatient hospital services for cases that are 20 days or more or are outlier cases
- Physician must certify or recertify no later than 20 days into the hospital stay:
  1. The reasons for either:
     i. continued hospitalization of the patient for medical treatment or medically required diagnostic study; or
     ii. special or unusual services for cost outlier cases
  2. The estimated time the patient will need to remain in the hospital
  3. The plans for post-hospital care, if appropriate

Inpatient-Only List

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Inpatient Only List

- CMS is not proposing to remove any procedures from the inpatient list for CY 2015
- CMS proposes to add CPT code 22222 (Osteotomy of the spine, including discectomy, anterior approach, single vertebral segment; thoracic) to the 2015 inpatient list
- Complete list of codes to be paid only in the inpatient setting is available in Addendum E on CMS' website

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High/Low Cost Threshold for Skin Substitutes

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Proposed High/Low Cost Threshold for Skin Substitutes

CY 2014 OPPS final rule:

- CMS unconditionally packaged skin substitute products into their associated surgical procedures
- CMS established a methodology to divide skin substitutes into a high cost group and a low cost group for packaging purposes
  - In high cost group: Skin substitutes with a July 2013 ASP + 6% amount above $32 per cm^2
  - In low cost group: Skin substitutes with a July 2013 ASP + 6% amount at/below $32 per cm^2

Proposed High/Low Cost Threshold for Skin Substitutes

For CY 2015, CMS proposes:

- A revised methodology to establish the high cost/low cost threshold
  - Would be based on the weighted average mean unit cost (MUC) for all skin substitute products from claims data
  - MUC threshold would be 27 per cm^2
    - MUC above \$27 per cm^2 → in high cost group
    - MUC at/below \$27 per cm^2 → in low cost group
  - If no claims data to calculate a MUC, CMS would use ASP + 6% payment rate
    - If that's not available, WAC + 6% or 95% of AWP

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Reasons for New Proposed Revised Methodology

- May provide more stable high/low cost categories
  - Addresses concern that as new high priced skin substitutes gain market share, the weighted average ASP high/low cost threshold could escalate rapidly, resulting in shift of many skin substitutes from high to low cost category
- Because revised threshold would be based on costs from outpatient claims data rather than manufacturer reported sales prices (including inpatient and outpatient sales), data would not include the larger product sizes and their lower per cm^2, used mainly for inpatient burn cases.

Proposed Pass-Through Evaluation Process for Skin Substitutes

CMS proposals, effective 2015:

- Evaluate applications for pass-through payment for skin substitutes using the medical device pass-through process and payment methodology.
- The last skin substitute pass-through applications evaluated using the drug and biological pass-through evaluation process would be those with an application deadline of Sept. 1, 2014, and an earliest effective date of Jan. 1, 2015.
- CMS also proposes to change Dec. 1, 2014 pass-through application deadline for both drugs and biologicals and devices to Jan. 15, 2015.

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Pass-Through Payments for Devices

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Pass-Through Payments for Devices

- CMS proposes **expiration** for one device category eligible for pass-through payment in 2015: HCPCS code C1841 (Retinal prosthesis, includes all internal and external components)
  - **Proposed expiration date for HCPCS code C1841: Dec. 31, 2015**
  - After Dec. 31, 2015, CMS proposes to package the cost of HCPCs code C1841 into the costs related to procedures with which it is reported in claims data (consistent with established policy).

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No Cost/Full Credit and Partial Credit Devices

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No Cost/Full Credit and Partial Credit Devices

- Current policy: CMS reduces the payment for selected device-dependent APCs by the estimated amount of the APC payment attributable to device costs if the hospital receives a device at no cost or with a full/partial credit.
- For CY 2015: CMS proposes to **continue** the policy of reducing OPPS payment by the full or partial credit a provider receives for a replaced device for specified device-dependent APCs.
- Hospitals required to report the amount of the credit in the amount portion for value code "FD" when the hospital receives a credit for a replaced device 50% or > than the device's cost.

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Pass-Through Payments for Drugs and Biologicals

Pass-Through Payments for Drugs and Biologicals

- Proposes to pay at ASP + 6% for CY 2015 (equivalent to physician's offices and same as CY 2014)
- Proposes to continue pass-through status or granted pass-through status as of July 2014 for 22 drugs and biologicals (Table 34 of the proposed rule)

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Payment Rate for Separately Payable Drugs and Biologicals

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Payment Rate for Separately Payable Drugs and Biologicals

- **CY 2015 packaging threshold = $90** (same as in 2014)
- **Proposed payment rate for separately payable drugs and non-implantable biologicals = ASP + 6%** (continues CY 2014 policy)
  - ASP-based payment rates for both the OPPS and physician office settings would continue to be updated quarterly using quarterly reported ASP data with a two-quarter lag.
  - Only HCPCS codes identified as separately payable in the final rule would be subject to quarterly updates.

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Payments to Certain Cancer Hospitals

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Payments to Certain Cancer Hospitals

- The ACA requires an adjustment for 11 cancer hospitals with outpatient costs higher than those of other hospitals
- **Proposed adjustment for cancer hospitals**: difference between cancer hospital's payment to cost ratio (PCR) and weighted average PCR of other hospitals
- **Proposal:**
  - Continue last year's policy of increasing each cancer hospital's PCR to equal PCR of other hospitals
  - For CY 2015, CMS calculates a target PCR of 0.89 (this year's estimated PCR of other hospitals)

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Payments to Certain Cancer Hospitals

- Estimated hospital-specific payment adjustment for the 11 cancer hospitals show increases in OPPS payments range from 15.5%-60.1%
- The 2015 budget neutrality adjustment to the OPPS conversion factor is 1.0000 for the cancer hospital adjustment
  - Reflects CMS' projection that aggregate cancer hospital adjustments will be largely unchanged in 2015 compared to 2014

Proposed Payment for PHP Services

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Proposed Payment for PHP Services

- CMS proposes to calculate the payment rates for the 4 partial hospitalization (PHP) APCs using geometric mean per diem costs.
  - The proposed per diem costs for hospital-based PHPs are lower (by approx. $14 for Level I and $24 for Level II PHP services) for hospital based PHPs than the final 2014 rates.
  - For CMHCs, the rates will decrease (by approx. $2 for Level I, but increase by approx. $3) for Level II services; so relatively constant
  - The proposed geometric mean per diem costs continue to be substantially lower for CMHCs than for hospitals.

Proposed 2015 Geometric Mean Per Diem Costs for PHP Services

Category	CMHC PHPs	Hospital-Based PHPs
Level I (days with 3 services)	APC 0172: $97.43	APC 0175: $177.32
Level II (days with 4 or more services)	APC 0173: $ 114.93	APC 0176: $ 190.21

Based on CMS estimates, payments to CMHCs will decline by 1.6 percent, due to the continuation of the four-separate-APC method of payment calculation and other adjustments.

Overpayments Associated with MA and Part D Data

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Overpayments Associated with MA and Part D Data

- CMS proposes a formal process to recoup overpayments resulting from submission of erroneous payment data by a MA organization (MAO) or Part D sponsor
  - Would apply when MAO or Part D sponsor fails to correct data after notice by CMS
  - Erroneous payment data = inaccurate or inconsistent with Part C and Part D requirements
  - Would not replace established recovery and appeals processes (i.e., the Risk Adjustment Data Validation, RADV) audit dispute and appeal process or the Part D payment appeals process)

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Overpayments Associated with MA and Part D Data

- If CMS identifies a payment data error that would result in overpayment, CMS would issue a corrections notice to the MAO or Part D sponsor identifying the error and the timeframe to correct it.
- Same 6-year look back period as applies for correction of plan-identified overpayments.
- If MAO or Part D sponsor does not submit corrected data in the timeframe, CMS would offset the payment error from plan payments.

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Quality Measures/Programs for CY 2017

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Quality Measures/Programs for CY 2017

- **Outpatient Quality Reporting (OQR) Program:**
  - One new measure proposed for inclusion (OP-32)
  - Three Measures proposed for removal due to being topped out (OP-4, OP-6, OP-7)
  - One proposed measure for voluntary reporting (OP-31)
- **Ambulatory Surgical Center Quality Reporting (ASCQR) Program:**
  - One measures proposed for inclusion (ASC-12)
  - One proposed measure for voluntary reporting (ASC-11)

Hospital Outpatient Quality Reporting (OQR) Program

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New Measure Proposed for CY 2017

- OP-32: Facility Seven Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
- Claims-based measure
- Measure is not NQF endorsed and was conditionally supported by the Measures Applications Partnership (MAP)

Measures Proposed for Removal in CY 2017 (Topped Out)

- OP-4: Aspirin at Arrival
- OP-6: Timing of Antibiotic
- OP-7: Prophylactic Antibiotic Selection for Surgical Patients

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Proposed Measure Delay (OP-31)

- CMS proposes to delay data collection for OP-31: Cataracts – Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery
  - CMS notes that the collection and reporting of this data is operationally difficult for hospitals; measure would also utilize inconsistent surveys to assess visual function
  - Proposed to be excluded from CY 2016 data collection
  - Proposed as a voluntary measure for CY 2017; data will be publicly reported
  - CMS also stated in the CY 2015 OPPS proposed rule that OP-31 had not yet been field tested in the HOPD facility setting

Data Collection Clarification (OP-29 & OP-30)

- CMS issued guidance in December 2013 delaying the start of the initial reporting period of two measures for three months:
  - OP-29: Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients
  - OP-30: Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use
- The data submission window did not change in the proposed rule for CY 2016 payment determination, and is still July 1, 2015 – November 1, 2015 for data collected April 1, 2014 – December 31, 2014

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Data Submission Requirements for Influenza Vaccination Measure

- The Influenza Vaccination Coverage among Healthcare Personnel (HCP) measure was finalized for both the outpatient and inpatient settings
- Two clarifications in the proposed rule:
  - Hospitals should report this measure by CMS Certification Number (CCN) rather than separately by setting
  - The deadline for reporting the summary data for CY 2016 payment determination is May 15, 2015 with respect to the October 1, 2014 through March 31, 2015 encounter period

Potential Future Expansion of OQR

- **E-measures**
  - CMS recognizes more work needed in this area
- **Partial Hospitalization Program (PHP)**
  Requested feedback on 3 PHP measures that were submitted to MAP
    - 30-Day Readmissions
    - Group Therapy
    - No Individual Therapy
- **Behavioral Health**
  - Topics such as depression and alcohol abuse
- **Other measures that align with the National Quality Strategy and CMS Quality Strategy Domains**

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Data Submission Timelines and Procedures for CY 2017

Chart Abstracted Measures

- Data must be submitted 4 months following the end of the calendar quarter
- 11 mandatory measures for CY 2017

Claims Based Measures

- Data calculations will be based on a 12-month period from July 1, 2014 through June 30, 2015
- 6 mandatory and 1 new proposed measures for CY 2017

Web-based Measures

- Data must be submitted between July 1, 2016 and November 1, 2016 with respect to performance on measures for CY 2015
- 4 mandatory measures for CY 2017

NHSN Measure

- Data must be reported via the CDC NHSN by May 15, 2016 for the period October 1, 2015 through March 31, 2016
- 1 mandatory measure for CY 2017 (healthcare worker vaccination measure) → combined inpatient and outpatient measure

Requirements for OQR mandatory measures only

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Ambulatory Surgical Center Quality Reporting (ASCQR) Program

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Proposed Process to Immediately Remove Measures

- Similar to the IQR Program, CMS proposes a process to immediately remove measures from the ASCQR Program if continued data collection may result in harm to patients
- If such situations occur, CMS would promptly retire the measure, immediately alert stakeholders, and confirm the measure's retirement in the next rulemaking cycle

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New ASC Measure Proposed for CY 2017

- ASC-12: Facility Seven Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
- Measure is not NQF endorsed and was conditionally supported by the Measures Applications Partnership (MAP)

Proposed Measure Delay (ASC-11)

- CMS proposes to delay data collection for ASC-11: Cataracts – Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery
  - CMS notes that the collection and reporting of this data is operationally difficult for ambulatory surgical centers. Measure would also utilize inconsistent surveys to assess visual function
  - Proposed to be excluded from CY 2016 data collection
  - Proposed as a voluntary measure for CY 2017

Data Collection Clarification (ASC-9 & ASC-10)

- CMS issued guidance in December 2013 delaying the start of the initial reporting period of two measures for three months:
  - ASC-9: Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients
  - ASC-10: Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use
- The data submission window did not change in the proposed rule for CY 2016 payment determination, and is still July 1, 2015 – November 1, 2015 for data collected April 1, 2014 – December 31, 2014

Proposed Data Submission Requirements for Influenza Vaccination Measure (ASCs)

- The Influenza Vaccination Coverage among Healthcare Personnel (HCP) measure was finalized for the ASC setting in the CY 2012 OPPS proposed rule
- CMS proposes that the deadline for reporting the summary data for CY 2016 payment determination be May 15, 2015 with respect to the October 1, 2014 through March 31, 2015 encounter period

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QUESTIONS?

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