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Tomorrow's Doctors, Tomorrow's Cures

CY 2014 Medicare Outpatient Prospective Payment System (OPPS) Final Rule

Learn
Serve
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Outpatient PPS Final Rule

- Published in *Federal Register* on December 10, 2013, at page 74826.
- Available at: http://www.gpo.gov/fdsys/pkg/FR-2013-12-10/pdf/2013-28737.pdf
- Comments are due to CMS no later than 5 p.m. EST on January 27, 2014.
- AAMC Data Analyses

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Topics for Today's Teleconference

- Market Basket Update
- Collapsing 5 E&M Codes into 1
- Collecting Data Re: Off-campus Provider-based Facilities
- Creation of New CCRs
- New Packaging Policy
- Creation of New "Comprehensive APCs"
- Inpatient-only List
- 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
- Physician Supervision
- "Incident to" Policy
- Clarification of Reopening of Predicate Facts
- Community Mental Health Centers (CMHCs)
- OQR/VBP/ASC Quality Programs Update

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CY 2014 OPPS Conversion Factor Update

- Use IPPS market basket increase = 2.5 percent
  - Less 2 percent if hospital doesn't submit quality data
- Less productivity adjustment = 0.5 percent
- Less ACA reduction = 0.3 percent
- Aggregate OPPS "update" = 1.8 percent
  - Major Teaching = 1.4 percent

Source: 78 *Fed. Reg.* 74949 - 74950

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Collapsing 5 Clinic Codes (but NOT ED codes) into 1 Code

- Currently 5 levels of clinic visits, Type A ED visits, and Type B ED visits, based on internal guidelines
- Final rule establishes 1 new code for clinic visits
  - Payment ($92.53) based on total mean cost of all 5 levels of E&M codes from 2012 claims
- Delays any changes to ED codes – may revisit after additional study
- No more distinction between new and established patient clinic visits
- Error in beneficiary copayment listed for new APC 0634 – printed as 40%; CMS corrected to 20%

Source: 78 *Fed. Reg.* 75038 - 75043

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Replacing Extended Assessment and Management (EAM) APCs into Single APC

- EAM = hospital visit with observation services of substantial duration
- Previously 2 APCs
- Finalized single new composite APC (8009)
- What qualifies for payment under this APC? All of the following if furnished by hospital in conjunction with observation services of substantial duration:
  - Clinic visits
  - Level 4 or Level 5 Type A ED Visit
  - Level 5 Type B ED Visit

Source: 78 *Fed. Reg.* 74910 - 74915

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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
- Considered collecting information on frequency, type, and payment for services furnished in off-campus provider-based departments, e.g.:
  - Claims-based approach (HCPCS modifier)
  - Break out costs & charges on cost report
- Decided NOT to collect this info at this point
  - No agreement on least administratively burdensome way to collect

Source: 78 *Fed. Reg.* 75061 - 75062

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New Cost to Charge Ratios (CCRs)

- CMS motivation? Address charge compression & resulting distortion of relative weights
- CMS finalized new CCRs for:
  - Cardiac catheterization
  - CT scan
  - MRI
- Note: for CT & MRI, CMS will remove claims from providers that use "square feet" cost allocation from 2014 - 2017
- Also finalizes continuing use of distinct CCR for implantable medical devices (first used in 2013)

Source: 78 *Fed. Reg.* 74840 - 74847

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New Packaging Policy

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New Packaging Policy

- CMS finalized to expand packaging to five categories of items and services
  1. Drugs, Biologicals, and Radiopharmaceuticals That Function as Supplies When Used in a Diagnostic Test or Procedure
  2. Drugs and Biologicals That Function as Supplies or Devices When Used in a Surgical Procedure
  3. Clinical Diagnostic Laboratory Tests
  4. Procedures Described by Add-On Codes
  5. Device Removal Procedures
- CMS did not finalize expanding packaging to:
  1. Ancillary Services (Status Indicator "X")
  2. Diagnostic Tests on the Bypass List

Source: 78 *Fed Reg.* 74925-74948

Packaging of Lab Tests

- CMS finalized its proposal to package lab tests when they are integral, ancillary, supportive, dependent or adjunctive to a primary service or services
- Lab test will not be packaged when:
  1. Lab test is the only service provided to beneficiaries on that date of service
  2. Test is conducted on the same date of service as the primary service but is ordered for a different purpose than the primary service by a different practitioner
- Molecular pathology tests are excluded from packaging (CPT codes 81200-81383, 81400-81408, and 81479)
- Packaging of lab tests has a -0.6% impact on major teaching hospitals

Source: 78 *Fed Reg.* 74834, 74925-74948

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Comprehensive APCs

Establishment of Comprehensive APCs

- CMS finalized proposal to establish 29 new comprehensive APCs to replace 29 existing device-dependent APCs (Table 8, *Fed. Reg.* p. 74870)
- Implementation is delayed until Jan. 1, 2015
  - Proposals are interim final; comments are due Jan. 27, 2014

Source: 78 *Fed Reg.* 74861-74901

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Comprehensive APCs: Included Services

- The following categories are included in the comprehensive APCs:
  - Otherwise Packaged Services and Supplies
  - Adjunctive Services
  - DMEPOS
  - OPD Services Reported by Therapy Codes
  - Hospital-Administered Drugs
- CMS did not finalize the proposal to include the costs reported with certain inpatient room, board, and nursing revenue codes

Source: 78 *Fed Reg.* 74861-74901

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Payment for Comprehensive APCs

- Claims processing system makes a single payment for the device-dependent comprehensive service whenever a HCPCS for a primary procedure (SI J1) appears on a claim
  - All other services (excl. mammography, ambulance, pass-through services) conditionally packaged
- CMS modified methodology for assigning J1 primary procedure to appropriate comprehensive APC when more than one J1 is reported

Source: 78 *Fed Reg.* 74861-74901

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Assigning J1 Primary Procedures

- CMS uses only current ratesetting estimated cost information, and not device-dependent APC payment rates, to identify the J1 primary procedure and the subsequent comprehensive APC
- APC recalibration; reevaluated proposed rule APC assignments of some primary procedures and moved some procedures from one APC to another
- Final rule establishes a comprehensive APC payment comparable to a severity level DRG payment adjustment

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Source: 78 *Fed Reg.* 74861-74901

Methodology for Complex Cases

Identify "primary HCPCS code"=code assigned to APC w/highest geometric mean cost (Column 7 of Table 9)

If multiple J1 codes on the claim are assigned to the same comprehensive APC, the methodology chooses the service w/highest geometric mean procedure cost (Column 6 of Table 9)

Reassigned to higher level APC in same clinical family if:

1) The comprehensive geometric mean cost > 2x the comprehensive geometric mean cost of claims reporting only a single J1 procedure

2) >100 claims with the specific combination of procedure codes

3) Claims reporting the specific combination >5% of total volume of claims reporting that procedure as primary service

4) Evaluate alternate APC assignments

Assignment of Combinations of J1 Procedures

- Table 10 (*Fed. Reg.* p. 74889) shows the comprehensive APC assignment of combinations of J1 procedures used to establish illustrative 2014 payment rates
  - Would contain same info as claims processing system
  - Used to determine final comprehensive APC assignment and geometric mean estimated cost for any J1 procedure reported on individual claims
  - Will be updated for 2015 using 2013 claims data

Source: 78 *Fed Reg.* 74861-74901

Pass-Through Payment for Devices and Drugs and Biologicals

Pass-Through Payments for Devices

- CMS finalized a clarification of the integral and subordinate criterion, §419.66(b)(3)
  - "integral" = "the device is necessary to furnish or deliver the primary procedure with which it is used"
  - Revised regulatory language:
    - "The device is an integral part of the service furnished, is used for one patient only, comes in contact with human tissue, and is surgically implanted or inserted whether or not it remains with the patient when the patient is released from the hospital."

Source: 78 *Fed Reg.* 75004-75005

No Cost/Full Credit and Partial Credit Devices

- For CY 2014, CMS finalized new policy for devices without costs or with a full/partial credit
  - Hospitals required to report the amount of the credit for value code "FD" when hospital receives a credit for device listed in Table 31 (*Fed. Reg.* p. 75009) that is 50% or greater than the cost of the device
    - Limits the OPPS payment deduction for the APCs listed in Table 30 (*Fed. Reg.* p. 75008) to the total amount of the device offset when the "FD" code appears on a claim
    - No longer use "FB" and "FC"

Source: 78 *Fed Reg.* 75005-75009

Pass-Through Payments for Drugs and Biologicals

- Finalized to be paid at ASP+6 percent for CY 2014 (equivalent to physician's offices and same as CY 2013)
- Finalized termination of pass-through status for 14 drugs and biologicals effective Jan. 1, 2014 (Table 32, *Fed. Reg*. p. 75011)
  - Modified proposal; pass-through status will continue in CY 2014 for HCPCS code Q4131
- Finalized to continue pass-through status for 18 drugs and biologicals (Table 33, *Fed. Reg*. p. 75014)

Source: 78 *Fed Reg.* 75010-75014

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Inpatient Only List

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Inpatient Only List

- CMS did not propose to remove any procedures from the inpatient list for CY 2014
- In response to commenter requests, CMS is adding 4 procedures to the inpatient only list

HCPCS Code	2014 SI
44206	C
44207	C
44208	C
44213	C

Complete list of 2014 inpatient only procedures in Addendum E (http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1601-FC-.html?DLPage=1&DLSort=2&DLSortDir=descending)

Source: 78 *Fed Reg.* 75054-75055

Payment Rate for Separately Payable Drugs and Biologicals

CY 2014 packaging threshold = $90 (up from $80 in 2013)

Proposed payment rate = ASP + 6% (continues CY 2013 policy)

- Payment represents combined acquisition and pharmacy overhead payment for drugs and biologicals.
- CMS continues policy of making an annual packaging determination for a HCPCS code in the OPPS final rule.

Source: 78 *Fed. Reg.* 75020-75022

Payments to Certain Cancer Hospitals

- The ACA requires an adjustment for 11 cancer hospitals with outpatient costs higher than those of other hospitals
- **Adjustment for cancer hospitals** = difference between cancer hospital's payment to cost ratio (PCR) and weighted average PCR of other hospitals
- **Continues last year's policy** of increasing each cancer hospital's PCR to equal PCR of other hospitals. CMS calculates a **target PCR of 0.89** (compared to the target PCR of 0.91 for 2013)
- Estimated hospital-specific payment adjustments for the 11 cancer hospitals for 2014 **range from 13.7% to 57.1%.**

Source: 78 *Fed. Reg.* 74956 - 74958

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Supervision of Hospital Outpatient Therapeutic Services

- **CMS ends nonenforcement policy for direct supervision of outpatient therapeutic services in CAHs and small rural hospitals beginning in 2014.**
  - CAHs and small rural hospitals have to comply with direct supervision requirements for all therapeutic services **except** those CMS identifies as appropriate for general supervision based on input from the Advisory Panel on Hospital Outpatient Payment.
  - CMS encourages hospitals to use the Advisory Panel process for potential changes to minimum supervision levels.

Source: 78 *Fed. Reg.* 75056 - 75057

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Supervision Requirements for Observation Services

- After receiving many questions about whether Medicare requires multiple evaluations of the patient during the provision of observation services (designated by CMS as nonsurgical extended duration therapeutic services),

- CMS clarifies that **once the supervising physician or appropriate NPP determines and documents the patient is stable, general supervision may be furnished throughout the duration of the observation service without additional initiation periods of direct supervision during the service**.

 Source: 78 *Fed. Reg.* 75056 - 75057

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"Incident to" services

- CMS adds a new condition of payment to the **"incident to"** regulations.
- Requires that hospital outpatient or CAH outpatient therapeutic "incident to" services be furnished in compliance with State scope of practice and other State rules related to health care delivery in the state in which the services are furnished.

Source: 78 *Fed. Reg.* 75058- 75061

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Clarification of Reopening of Predicate Facts

- **CMS' response to *Kaiser Foundation Hospitals v. Sebelius* (D.C. Cir. 2013)**: modifies the reopening regulation to clarify that factual findings that affect reimbursement are subject to change **only** through timely appeal or reopening for the fiscal period in which the fact first arose or was determined by the intermediary; and
- The application of the fact is subject to change **only** through a timely appeal or reopening of a cost report for the fiscal period in which it was first used by the intermediary to determine reimbursement.

Source: 78 *Fed. Reg.* 75162 - 75169

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Payment for PHP Services

Proposed Payment for PHP Services

- CMS will calculate the payment rates for the 4 partial hospitalization (PHP) APCs using geometric mean per diem costs.
  - Hospital-based PHPs:
    - receive an increase in geometric mean per diem costs from 2013 to 2014 for APC 0175 Level I (days with 3 services) from $185.90 to $190.82
    - But receive a decrease for APC 0176 Level II (days with 4 or more services) from $234.81 to $214.39 in 2014 due to costs associated with PHP services and other final rule changes, e.g. budget neutral changes in relative payment rates.
  - Geometric mean per diem costs remain substantially lower for CMHCs than for hospitals.

Source: 78 *Fed. Reg.* 75045 - 75050

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Separate Threshold for Outlier Payments to CMHCs

- A portion (0.0016%) of the estimated 1.0% outlier target amount will be designated specifically for CHMCs for PHP outliers.
- CMHC outlier payment = 50% of the difference between the CMHC's cost for the services and the product of 3.40 times the APC 0173 payment rate.

Source: 78 *Fed. Reg.* 75053 - 75054

Possible Future PHP Initiatives

- **CMS sought comments on ways to change the payment structure for PHP services. Most commenters:**
  - Rejected changing to an episode of care-based payment system and urged CMS to create a rate-setting task force to develop a new payment methodology.
  - Rejected changing current physician certification and recertification requirements
  - Supported most additional requirements for the physician individualized written plan of treatment except for the PHP providing a "confirmed place of residence in a stable environment with support services."

 Source: 78 *Fed. Reg.* 75050 - 75053

Hospital Outpatient Quality Reporting (OQR) Program

Four New Measures Finalized for CY 2016

NQF Number	Measure Identifier/Title
#0431	OP-27: Influenza Vaccination Coverage Among Healthcare Personnel
#0658	OP-29: Endoscopy/Poly Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients
#0659	OP-30: Endoscopy/Poly Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use
#1536	OP-31: Cataracts- Improvement in Patients Visual Function within 90 Days Following Cataract Surgery

Not Finalized:
OP-28: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures

Source: 78 *Fed. Reg.* 75096-75102

Influenza Vaccination Coverage Among Healthcare Personnel

- Measure already finalized for both inpatient and ambulatory surgical center quality reporting programs
- Reported through the Centers for Disease Control's (CDC) National Healthcare Safety Network (NHSN)
  - Hospitals already reporting this data for IQR will not need to re-enroll with NHSN (use same certification number)
- CMS will provide additional guidance on the appropriate attribution of outpatient healthcare personnel in the December 2013 addendum to the Hospital OQR Specifications Manual on qualitynet.org
- Definitions of healthcare personnel for purposes of the IQR program will also be clarified in the IQR specifications manual in April, 2014
- CMS will also provide future guidance on reporting this measure in the 2015 rulemaking cycle

Source: 78 *Fed. Reg.* 75097-75099

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Two Measures Finalized for Removal

Measure Identifier/Name
• OP-19: Transition Record with Specified Elements Received by Discharged Patients
• OP-24: Cardiac Rehabilitation Measures: Patient Referral from an Outpatient Setting

- **These measures are finalized for removal starting with CY 2015 payment determination**

Source: 78 *Fed. Reg.* 75092-75095

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Data Submission Timelines and Procedures for CY 2016

Chart Abstracted Measures	• Data submission timelines: 4 months following the end of the calendar quarter
Claims Based Measures	• Data calculations is based on a 12-month period from July 1, 2013 through June 30, 2014
Web-based Measures	• Aggregate data must be submitted between July 1, 2015 and November 1, 2015 with respect to performance on measures for CY 2014. • This applies to newly finalized measures: OP-29, OP-30, and OP-31 • Measures will be displayed on Hospital Compare in December of 2015
NHSN Measure	• Data on OP-27: Influenza Vaccination Coverage among Healthcare Personnel must be reported via the CDC NHSN by May 15 for the period October 1 through March 31 • Hospitals already reporting this data for IQR will not need to re-enroll with NHSN (use same certification number)

Two new policies in the final rule regarding the web-based measures:

- Sampling methodology
- Low-case threshold exemption

Source: 78 *Fed. Reg.* 75109-75118

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Additional Finalized Changes to Reporting Requirements

- Starting CY 2014, CMS will grant extraordinary circumstance waivers/extensions if there are systemic problems with data collection systems
- Starting CY 2015, the deadline for reconsideration requests moved from February 3 to the first business day in February of the affected payment year

Source: 78 *Fed. Reg.* 75118-75120

Value Based Purchasing (VBP) Program

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Two Finalized Additions for VBP in FY 2016

- Baseline and performance periods for CLABSI, CAUTI, and SSI measures for FY 2016
  - CMS finalized CY 2014 as the Performance period and CY 2012 as the baseline period for these measures
- Implementation of additional CMS review process
  - CMS included an additional Independent review process for hospitals dissatisfied with the outcome of their appeal

Source: 78 *Fed. Reg.* 75120-75121

Ambulatory Surgical Center Quality Reporting (ASCQR) Program

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Three ASC Quality Measures Finalized for CY 2016

NQF Number	Measures
#0658	Endoscopy/Poly Surveillance: Appropriate follow-up interval for normal colonoscopy in average risk patients
#0659	Endoscopy/Poly Surveillance: Colonoscopy interval for patients with a history of adenomatous polyps- avoidance of inappropriate use
#1536	Cataracts- improvement in patients visual function within 90 days following cataract surgery

Not Finalized:
Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures

Source: 78 *Fed. Reg.* 75124-75130

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QUESTIONS?

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