

PUBLICATION

CMS Releases CY 2014 Hospital OPPS and ASC Final Rule [Ober|Kaler]

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CMS has published its [Calendar Year \(CY\) 2014 Final Rule \[PDF\]](#) for Medicare policy and payment rates for hospital outpatient prospective payment systems (OPPS) and Ambulatory Surgical Center (ASC) services. This final rule with comment period updates payment policies and payment rates for services reimbursed under the Medicare OPPS and ASC payment systems, including significant changes to package five new categories of items and services reimbursed under OPPS, establishing 29 comprehensive ambulatory payment classifications (APCs) to prospectively pay for the most costly hospital outpatient device-dependent services, and creating a single level of payment for hospital outpatient clinic visits. CMS anticipates that total CY 2014 OPPS payments are projected to increase by \$4.4 billion or 9.5 percent, and CY 2014 Medicare payments to ASCs are projected to increase by approximately \$143 million or 5.3 percent as compared to CY 2013. The comment period on certain HCPCS codes identified in Addenda B, AA, and BB of the final rule, as well as other designated issues in the final rule, including comprehensive APCs, runs through **January 27, 2014**.

The following is a brief description of some of the major changes contained in the final rule:

OPPS Payment Update

CMS is increasing the OPPS market basket by 1.7 percent. This amount was determined based on the final inpatient hospital market basket percentage for fiscal year (FY) 2014 of 2.5, as reduced by the multifactor productivity (MFP) adjustment of 0.5 percentage points and a 0.3 percentage point adjustment required under the Affordable Care Act (ACA).

Packaged Items or Services

In an effort to purportedly move the OPPS from acting as more of a fee schedule to the prospective payment system it is intended to be, CMS finalized its proposal to package five new categories of items and services to a single payment under 42 C.F.R. § 419.2. For certain cases, a separate payment would be made *only* if the item or service is furnished on a different date of service as the primary service. The five new categories of packaged services include:

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 when used in a surgical procedure, including skin substitutes. Skin substitutes will be classified as either high cost or low cost and will be packaged into the associated surgical procedures with other skin substitutes of the same class;
3. Certain clinical diagnostic laboratory tests (other than molecular pathology tests) that are integral, ancillary, supportive, dependent, or adjunctive to the primary services provided in the outpatient setting. CMS considers a laboratory test to be unrelated to the primary service and, therefore, not part of the packaging policy *only* if the laboratory test is the only service provided on a date of service, or if the laboratory test is on the same date of service as the primary service but is ordered for a different purpose and by a different practitioner than the practitioner who ordered the primary service;

4. Certain procedures described by add-on codes. Add-on codes describe procedures that are always performed in addition to the primary procedures. CMS proposes to unconditionally package add-on codes listed in Addendum P to the proposed CY 2014 OPPTS/ASC rule, which is available on the CMS website; and
5. Device removal procedures to the extent that the removal procedure is performed as part of an overall procedure for repairing or replacing the device.

Establishing Comprehensive APCs

The rule replaces the 29 existing costly device-dependent APCs with comprehensive APCs that prospectively pay for the primary service and all adjunct services. CMS will make a single payment for the comprehensive service based on all charges on the claim, excluding only charges for services not covered by Medicare Part B or that are not payable under OPPTS. CMS will apply a complexity adjustment for the most complex multiple device claims. The implementation date for this change is delayed until CY 2015 for operational reasons, and CMS invites comments on this section of the final rule.

Collapsing Five Levels of Clinic Visits to One

The five levels of outpatient clinic visit codes have been restructured and replaced with a single Healthcare Common Procedure Coding System (HCPCS) code describing all clinic visits. CMS states that a single code and payment for clinic visits is more administratively simple for hospitals and better reflects hospital resources involved in supporting an outpatient visit. The current five levels of outpatient visit codes were created to differentiate physician work.

Importantly, CMS is not substituting a single visit code for the current five levels of codes for each type of emergency department visits at this time.

Part B Drugs in the Outpatient Department

The rule finalizes the proposal to continue paying at ASP+6 percent for non-pass-through drugs and biologicals that are payable separately under the OPPTS.

ASC Payment Update

ASC payments are updated for inflation annually by the percentage increase in the consumer price index for all urban consumers (CPI-U). The Medicare statute specifies a MFP adjustment to the ASC annual update. For CY 2014, the CPI-U update is projected to be 1.7 percent. The MFP adjustment is projected to be 0.5 percent, resulting in an MFP-adjusted CPI-U update of 1.2 percent for CY 2014. The annual update is reduced by two percent for ASCs that fail to meet ASC Quality Reporting Program requirements.

Partial Hospitalization Program (PHP) Rates

CMS updates the two payment rates for community mental health centers and the two payment rates for hospital-based PHPs. For community mental health centers, the final CY 2014 geometric mean per diem cost for Level I (three services) is \$99 and for Level II (four or more services) is \$112. For hospital-based PHPs, the final CY 2014 geometric mean per diem cost is \$191 for Level I and \$214 for Level II.

Hospital Outpatient Quality Reporting (OQR) Program

The rule finalizes four new measures for the OQR program, affecting the CY 2016 payment determination and subsequent years, with data collection beginning in CY 2014:

6. *Influenza Vaccination Coverage among Healthcare Personnel* (OP-27) (NQF #0431);
7. *Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average-Risk Patients* (OP-29) (NQF #0658);
8. *Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use* (OP-30) (NQF #0659); and
9. *Cataracts - Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery* (OP-31) (NQF #1536).

The final rule also removes two measures for the CY 2015 payment determination and subsequent years:

- *Transition Record with Specified Elements Received by Discharged ED Patients* (OP-19) (NQF# 0649), because this measure cannot be implemented with the degree of specificity needed to fully address stakeholders' concerns without being overly burdensome to both hospitals and CMS; and
- *Cardiac Rehabilitation Measure: Patient Referral from an Outpatient Setting* (OP-24) (NQF# 0643), due to continued difficulties accurately applying the measure to the hospital outpatient setting without creating undue burden on providers.

Additionally, the final rule codifies several administrative requirements and clarifies that the extraordinary circumstances waiver/extension includes certain systemic issues.

ASC Quality Reporting (ASCQR) Program

The final rule adopts the same two colonoscopy measures, as well as the cataract measure, for the ASCQR Program as were added to the Hospital OQR program for the CY 2016 payment determination and subsequent years.

Hospital Value-Based Purchasing (VBP) Program

The rule sets performance and baseline periods for the catheter-associated urinary tract infection (CAUTI), central line-associated bloodstream infection (CLABSI), and surgical site infection (SSI) measures for the FY 2016 Hospital VBP Program. The final performance period is January 1, 2014 through December 31, 2014, and the final baseline period is January 1, 2012 through December 31, 2012. CMS also creates a second level independent review process for hospitals that are dissatisfied with the result of their administrative appeal regarding their VBP score.

Organ Procurement Organizations (OPO) Conditions for Coverage

The rule finalizes the proposal to eliminate the requirement for OPOs to meet all three of the outcome measures. CMS will consider OPOs to be in compliance with the outcome measures if they meet two out of the three outcome measures. According to CMS, these OPOs are performing satisfactorily and should not be decertified based solely on their failure to meet one outcome measure.

Quality Improvement Organization (QIO) Changes

The rule finalizes changes to the regulations governing eligibility for organizations to be QIOs and the contracting process for QIOs. The revisions are designed to improve QIOs' quality improvement initiatives and case review activities and improve the QIOs' ability to meet the needs of Medicare beneficiaries by incorporating changes to the QIO statute made by the Trade Adjustment Assistance Extension Act of 2011 (TAAEA).

Changes to the Medicare Electronic Health Record (EHR) Incentive Program. CMS is revising its regulations to provide a special method for making payments for 2014 for eligible professionals who reassign their benefits to Method II critical access hospitals (CAHs).

“Predicate Facts” Not Subject to Reopening After the 3-Year Reopening Period

CMS finalizes its proposal to apply the 3-year reopening rules to cut off providers' appeal and reopening rights with respect to “predicate facts,” i.e., factual underpinnings of a specific determination of the amount of reimbursement due to a provider that may first arise in, or be determined for, a different fiscal period than the cost reporting period under review. Under the new rule, if more than 3 years have expired since the initial determination, that determination may not be reopened to revise the predicate facts as they are used in the year under review.

Outpatient Therapeutic Services

CMS will allow its non-enforcement instruction for the direct physician supervision of outpatient therapeutic services furnished in CAHs and small rural hospitals to expire at the end of CY 2013. In addition, CMS amends the conditions of payment for “incident to” hospital or CAH outpatient services to explicitly require that individuals furnishing these services must provide the services in accordance with state law.