Health Law Daily Wrap Up, OUTPATIENT HOSPITALS—FINAL RULES: CMS projects OPPS payments for 2014 to increase by 9.5 percent, (Dec. 10, 2013)

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Payments under the Outpatient Prospective Payment System (OPPS) Final rule for calendar year (CY) 2014 Medicare payments to hospitals are projected to increase by $4.4 billion or 9.5 percent and payments to ambulatory surgical centers (ASCs) are projected to increase by approximately $143 million or 5.3 percent, according to a CMS Fact Sheet providing details of the final rule. In its press release, CMS stated that the Final rule increases overall payments for hospital outpatient departments by an estimated 1.7 percent for CY 2014. The increase is based on the projected hospital market basket of 2.5 percent, minus both a 0.5 percent adjustment for economy-wide productivity and a 0.3 percentage point adjustment required by statute (Final rule, 78 FR 74826, December 10, 2013).

Coding changes. The Final rule replaces the current five levels of outpatient clinic visit codes for both new and established patients with a single health care common procedure coding system (HCPCS) code describing all clinic visits. According to CMS, the 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 Final rule does not finalize the proposal to replace the current five levels of codes for each type of emergency department visits.

Packaged services. To move OPPS closer to a prospective payment system similar to the Medicare payment system for inpatient hospital services and less like a fee schedule, CMS has expanded the categories of packaged items and services into primary services by adding five additional categories of supporting services. The five categories 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, which will be classified as either high cost or low cost and packaged into the associated surgical procedures with other skin substitutes of the same class; (3) certain clinical diagnostic laboratory tests; (4) certain procedures described by add-on codes; and (5) device removal procedures.

A proposal to establish an encounter-based or “comprehensive” payment for certain device-related procedures like cardiac stents and defibrillators (creating 29 comprehensive ambulatory procedure codes (APCs) to replace 29 existing device-dependent APCs) has been finalized with a modification to apply a complexity adjustment for the most complex multiple device claims; however, CMS delayed the effective date for these comprehensive APCs until CY 2015.

Other payment updates. CMS will continue paying for nonpass-through drugs and biologicals that are payable separately under the OPPS at the average sale price plus 6 percent. In addition, CMS adopted its proposal to update the two payment rates for community mental health centers and the two payment rates for hospital-based partial hospitalization services (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), $112. For hospital-based PHPs, the final CY 2014 geometric mean per diem cost is $191 for Level I and $214 for Level II.

Quality improvement programs. In addition to codifying several administrative requirements and providing clarification, four new measures for the Hospital Outpatient Quality Reporting program affecting the CY 2016 payment determination and subsequent years with data collection beginning in CY 2014 have been finalized. The new measures include a measure for influenza vaccination coverage among healthcare personnel; two measures related to colonoscopies, and a measure related to improvement in vision following cataract surgery.
The two colonoscopy measures and the cataract measure have been adopted for the ASC Quality Reporting Program (ASCQR) for the CY 2016 payment determination and subsequent years.

Two measures for the CY 2015 payment determination and subsequent years have been removed: transition record with specified elements received by discharged emergency department patients and cardiac rehabilitation measure: patient referral from an outpatient setting. For the FY 2016 Hospital Value Based Purchasing Program, the Final rule sets performance and baseline periods for the catheter-associated urinary tract infection, central line-associated bloodstream infection, and surgical site infection measures. The rule also creates a second level independent CMS review process for hospitals that are dissatisfied with the result of their existing administrative appeal.

**Other changes.** CMS adopted its proposal to eliminate the requirement for Organ Procurement Organizations (OPOs) to meet all three of the outcome measures. Under the Final rule, OPOs will be in compliance with the outcome measures if they meet two out of the three outcome measures. The Final rule amends the regulations governing eligibility for organizations to be Quality Improvement Organizations (QIOs) and the contracting process for QIOs to improve QIOs’ quality improvement initiatives and case review activities as well as incorporating the changes made to the QIO statute by the Trade Adjustment Assistance Extension Act of 2011 (TAAEA) to improve QIO’s ability to meet the needs of Medicare beneficiaries. The Final rule also addresses the Provider Reimbursement Determinations and Appeals policy and makes changes to the Medicare EHR Incentive Program that affects eligible professionals who reassign their benefits to Method II Critical Access Hospitals.