Regulatory Update

## Final Rule Summary

# Medicare Outpatient Prospective Payment System for Calendar Year 2015

December 2014

FHA Florida Hospital Association

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## OVERVIEW

The final calendar year (CY) 2015 payment rule for the Medicare outpatient prospective payment system (OPPS) was published in the November 10, 2014, *Federal Register*. The rule includes annual updates to the Medicare fee-for-service (FFS) outpatient payment rates as well as regulations that implement new policies:

- Implementation of 25 new comprehensive ambulatory payment classifications (C-APCs) that bundle all payments for certain device-dependent procedures;
- Expansion of the list of services to be packaged into APCs as opposed to separately paid;
- Adoption of new Core-Based Statistical Area (CBSA) delineations for determining wage indexes;
- New data collection requirement for type and frequency of outpatient hospital and physician services furnished in off-campus provider-based clinics;
- Revision to the physician certification requirements for inpatient hospital services;
- Updated payment rates and policies for ambulatory surgical centers (ASCs);
- Establishment of an appeals process for Medicare Advantage (MA) organizations and Part D sponsors that would be applicable to CMS-identified overpayments to these entities; and
- Changes to the data sources used for expansion requests for physician-owned hospitals under the physician self-referral regulations.

A copy of the *Federal Register* and other resources related to the OPPS are available on the CMS Web site at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1613-FC.html?DLPage=1&DLSort=2&DLSortDir=descending.

### OPPS Payment Rate

*Federal Register* pages 66824-66826

The tables below show the final CY2015 conversion factor compared to CY2014 and the components of the update factor:

| | Final CY2014 | Final CY2015 | Percent Change |
|---|---|---|---|
| OPPS Conversion Factor | $72.672 | $74.144 | +2.0 |

| Final CY2015 Update Factor Component | Value (percent) |
|---|---|
| Market Basket Update | +2.9 |
| Patient Protection Affordable Care Act (PPACA)-Mandated Productivity Market Basket Reduction | -0.5 |
| PPACA-Mandated Pre-Determined Market Basket Reduction | -0.2 |
| Wage Index Budget Neutrality Adjustment | -0.04 |
| Pass-through Spending Budget Neutrality Adjustment | -0.13 |
| ***Overall Final Rate Update*** | **+2.0** |

## ADJUSTMENTS TO THE OUTPATIENT RATE AND PAYMENTS

### Wage Indexes and New CBSA Delineations

*Federal Register* pages 66826-66828

As in past years, for CY2015 OPPS payments, CMS will use the federal fiscal year (FY) 2015 inpatient prospective payment system (IPPS) wage indexes, including all reclassifications, add-ons, rural floors, and budget neutrality adjustment. This means that the CY2015 OPPS wage indexes will be updated to reflect the new CBSA delineations as adopted for the IPPS.

The CY2015 CBSA changes are based on the 2010 Census and include:

- Newly created CBSAs;
- Urban counties that will become rural;
- Rural counties that will become urban; and
- Existing CBSAs that will be split apart or incorporate additional counties.

The new delineations may also have an effect on:

- Hospital reclassifications under the Medicare Geographic Classification Review Board (MGCRB);
- The treatment of hospitals with Lugar status;
- Sole Community Hospitals that receive the 7.1 percent rural add-on;
- Hospitals that reclassify as rural; and
- The applicability of the out-migration adjustment.

CMS will provide a one-year transitional wage index for any hospital that experiences a wage index decrease (post-reclassification) that is due solely to the new CBSA delineations. The transitional value is applicable in CY2015 only, and will utilize the same wage data, with 50 percent based on the current CBSA delineations and 50 percent based on the new CBSA delineations (the out-migration adjustment is applied after the 50/50 blend is calculated). The transitional wage index will expire in CY2016. In some very limited circumstances (i.e., urban to rural changes that affect geographic location or Lugar status), CMS will provide a longer, three-year transition to the new wage index.

The wage index is applied to the portion of the OPPS conversion factor that CMS considers to be labor-related. For CY2015, CMS will continue to use a labor-related share of 60 percent.

### Effect of Sequestration

No *Federal Register* page reference

The final rule does not specifically address the 2.0 percent sequester reductions to all Medicare payments (authorized by Congress and currently in effect through FY2024). Sequester is not applied to the payment rate, instead, it is applied to Medicare claims after determining co-insurance, any applicable deductibles, and any applicable Medicare secondary payment adjustments. Other Medicare payment lines such as graduate medical education (GME), bad debt, and electronic health

record (EHR) incentives are also affected by the sequester reductions. Payments from MA plans should not be automatically impacted by sequester.

**Outlier Payments**
*Federal Register* pages 66832-66834

To maintain total outlier payments at 1.0 percent of total OPPS payments, CMS has set a final CY2015 outlier fixed-dollar threshold of $2,775. This is a decrease compared to the current threshold of $2,900. Outlier payments will continue to be paid at 50 percent of the amount by which the hospital's cost exceeds 1.75 times the APC payment amount when both the 1.75 multiple threshold and the fixed-dollar threshold are met.

**Payment Increase for Rural SCHs and EACHs**
*Federal Register* pages 66830-66831

CMS will continue to apply a 7.1 percent payment increase for rural Sole Community Hospitals (SCHs) and Essential Access Community Hospitals (EACHs). This payment add-on excludes separately payable drugs and biologicals, devices paid under the pass-through payment policy, and items paid at charges reduced to costs.

**Cancer Hospital Payment Adjustment and Budget Neutrality Effect**
*Federal Register* pages 66831-66832

CMS will continue its policy to provide payment increases to the 11 hospitals identified as exempt cancer hospitals. This policy will continue to be applied in a budget neutral manner. Because CMS applied a budget neutrality reduction in CY2012 when this adjustment was first implemented, there is no year-to-year change in the conversion factor as a result of continuing this policy.

**Updates to the APC Groups and Weights**
*Federal Register* pages 66780-66824 and 66837-66895

As required by law, CMS must review and revise the APC relative payment weights annually. CMS must also revise the APC groups each year to take into account drugs and medical devices that no longer qualify for pass-through status, new and deleted Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes, advances in technology, new services, and new cost data.

The finalized payment weights and rates for CY2015 are available in Addenda A and B of the final rule at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1613-FC.html?DLPage=1&DLSort=2&DLSortDir=descending

The table below shows the shift in the number of APCs per category from CY2014 to CY2015:

| APC Category | Status Indicator | Final CY2014 | Final CY2015 |
|---|---|---|---|
| Clinic or Emergency Department Visit | V | 15 | 15 |
| Procedure or Service, Multiple Reduction Applies | T | 181 | 129 |
| Procedure or Service, No Multiple Reduction | S | 131 | 134 |
| Ancillary Services | X | 38 | 0 |
| Pass-Through Devices Categories | H | 1 | 2 |
| OPD Services Paid through a Comprehensive APC | J1 | 0 | 25 |
| Non-Pass-Through Drugs/Biologicals | K | 284 | 289 |
| Partial Hospitalization | P | 4 | 4 |
| Blood and Blood Products | R | 34 | 34 |
| Brachytherapy Sources | U | 16 | 17 |
| Pass-Through Drugs and Biologicals | G | 26 | 35 |
| New Technology | S/T | 82 | 82 |
| **Total** | | **812** | **766** |

**New Comprehensive APCs for Device-Dependent Procedures**
*Federal Register* pages 66798-66810

Last year, CMS adopted a number of refinements to the APC assignments in an effort to create larger payment bundles. For CY2015, CMS is implementing its 2014 proposals, with slight modifications, to create larger payment bundles by expanding its packaging policies and implementing new comprehensive APCs.

C-APCs will be applicable for certain medical device implantation procedures. One C-APC will cover payment for all Part B services that are related to the device-dependent procedure (including items currently paid under separate fee schedules). The C-APC will encompass diagnostic procedures, lab tests, and treatments that assist in the delivery of the primary procedure, visits and evaluations performed in association with the procedure, coded and un-coded services and supplies used during the service, outpatient department services delivered by therapists as part of the comprehensive service, durable medical equipment as well as the supplies to support that equipment, and any other components reported by HCPCS codes that are provided during the comprehensive service. The costs of blood and blood products are included in the C-APCs.

The C-APCs will not include payments for services that are not covered by Medicare Part B or that are not payable under OPPS such as certain mammography and ambulance services, brachytherapy sources, pass-through drugs and devices, and charges for self-administered drugs (SADs). A full list of excluded services is provided in Table 6 of the final rule.

CMS has created a new status indicator: "J1 – complexity-reassignment," for the device-dependent procedures that will be assigned to a C-APC. To address potential cost-variation within the C-APCs, CMS will apply a complexity adjustment when particular combinations of device-dependent procedures are reported on the same claim, thereby creating severity levels for the C-APCs. Outpatient claims with multiple J1 procedures will be assigned to a C-APC based on the highest APC geometric mean cost. CMS is also adopting the following criteria to evaluate HCPCS code combinations for complexity adjustments:

- *"Frequency of 25 or more claims reporting the HCPCS code combination (the frequency threshold); and*
- *Violation of the '2 times' rule (the cost threshold)."*

A list of the final complexity adjustments by primary HCPCS and APC is available in Addendum J of the final rule.

Based on CMS' final rule, there will be a total of 25 C-APCs within 12 clinical families for CY2015, as listed in the table below (highlighting added to indicate the clinical families). CMS is not finalizing its proposal to treat APCs 0427, 0622 and 0652 as C-APCs and notes that additional procedures may be added to the C-APC policy in future years, as a part of a broader packaging initiative.

| Clinical Family | APC | APC Title | Final CY2015 APC Payment Rate |
|---|---|---|---|
| AICDP | 0090 | Level II Pacemaker/Similar Procedures | $6,543 |
| AICDP | 0089 | Level III Pacemaker/Similar Procedures | $9,490 |
| AICDP | 0655 | Level IV Pacemaker/Similar Procedures | $16,401 |
| AICDP | 0107 | Level I ICD and Similar Procedures | $22,908 |
| AICDP | 0108 | Level II ICD and Similar Procedures | $30,806 |
| BREAS | 0648 | Level IV Breast and Skin Surgery | $7,461 |
| ENTXX | 0259 | Level VII ENT Procedures | $29,707 |
| EPHYS | 0084 | Level I Electrophysiologic Procedures | $873 |
| EPHYS | 0085 | Level II Electrophysiologic Procedures | $4,633 |
| EPHYS | 0086 | Level III Electrophysiologic Procedures | $14,357 |
| EYEXX | 0293 | Level IV Intraocular Procedures | $8,447 |
| EYEXX | 0351 | Level V Intraocular Procedures | $23,075 |
| GIXXX | 0384 | GI Procedures with Stents | $3,174 |
| NSTIM | 0061 | Level II Neurostim./Related Procedures | $5,289 |
| NSTIM | 0039 | Level III Neurostim./Related Procedures | $17,099 |
| NSTIM | 0318 | Level IV Neurostim./Related Procedures | $26,152 |
| ORTHO | 0425 | Level V Musculoskeletal Procedures | $10,220 |
| PUMPS | 0227 | Implantation of Drug Infusion Device | $15,566 |
| RADTX | 0067 | Single Session Cranial SRS | $9,765 |
| UROGN | 0202 | Level V Gynecologic Procedures | $3,978 |
| UROGN | 0385 | Level I Urogenital Procedures | $6,822 |
| UROGN | 0386 | Level II Urogenital Procedures | $13,968 |
| VASCX | 0083 | Level I Endovascular Procedures | $4,537 |
| VASCX | 0229 | Level II Endovascular Procedures | $9,624 |
| VASCX | 0319 | Level III Endovascular Procedures | $14,841 |

AICDP = Automatic Implantable Cardiac Defibrillators, Pacemakers, and Related Devices; BREAS = Breast Surgery; ENTXX = ENT Procedures; EPHYS = Cardiac Electrophysiology; EYEXX = Ophthalmic Surgery; GIXXX = Gastrointestinal Procedures; NSTIM = Neurostimulators; ORTHO = Orthopedic Surgery; PUMPS = Implantable Drug Delivery Systems; RADTX = Radiation Oncology; UROGN = Urogenital Procedures; VASCX = Vascular Procedures.

In conjunction with the new C-APC policy, CMS is eliminating its edit policy requiring specific procedure-to-device and device-to-procedure combinations to be included on the OPPS claim. Hospitals are still expected to adhere to the guidelines of correct coding and append the correct device code to the claim, when applicable, however, no longer will claims be returned when these

specific procedure and device code pairings do not appear. Table 5 includes all device dependent APCs that require a device code.

**Packaged Services**
*Federal Register* pages 66817-66823

For CY2015, CMS is continuing its efforts to create larger payment bundles by expanding its packaging policies to the following services/items:

- Ancillary services with a geometric mean cost of less than or equal to $100 – CMS' stated intention, over time, is to package more ancillary services when they occur on a claim with another service, and only pay for them separately when performed alone. There are 326 ancillary services currently paid separately under the OPPS that will be packaged in CY2015 under certain conditions. 116 ancillary services will remain separately paid (assigned a status indicator of S or T) because CMS has identified them as exceeding the $100 threshold or as services that are preventative or psychiatry/counseling-related. With this expanded packaging, CMS is eliminating the "X" Status Indicator.

- Prosthetic supplies – Currently, all prosthetic supplies are paid under the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule, even when provided in the hospital outpatient department. However, implantable prosthetics and medical and surgical supplies are paid under OPPS.

  Beginning in CY2015, prosthetic supplies provided in the hospital outpatient departments (HOPDs) will be included in the packaged category of "medical and surgical supplies." A list of the HCPCS codes for prosthetic supplies that will be packaged for CY2015 are available in Addendum B.

**Composite APCs**
*Federal Register* pages 66810-66816

Composite APCs are another type of packaged payment that provide a single payment for groups of services that are typically performed together during a single outpatient encounter. Currently, there are ten composite APCs for:

- Low-Dose Rate (LDR) Prostate Brachytherapy (APC 8001);
- Cardiac Electrophysiologic Evaluation and Ablation Services (APC 8000);
- Mental Health Services (APC 0034);
- Multiple Imaging Services (APCs 8004, 8005, 8006, 8007 and 8008);
- Extended Assessment and Management (EAM) Services (APC 8009); and
- Cardiac Resynchronization Therapy (APC 0108).

To ensure alignment with the new C-APC policies, CMS is discontinuing two of these composite APCs: APC 8000, which will be replaced by C-APC 0086 (Level III Electrophysiologic Procedures), and APC 0108 which will be replaced by C-APC 0108 (Level II ICD and Similar Procedures). Table 9 on pages 66814-66816 of the *Federal Register* shows the HCPCS codes that are eligible for composite APC assignment.

**Payment for Drugs, Biologicals and Radiopharmaceuticals**
*Federal Register* pages 66874-66895

CMS pays for drugs and biologicals that do not have pass-through status in one of two ways: either packaged into the APC for the associated service or assigned to their own APC and paid separately. The determination is based on a price threshold.

For CY2015, CMS has set a packaging threshold of $95. Drugs, biologicals and radiopharmaceuticals that are above the $95 threshold are paid separately using individual APCs, the payment rate for CY2015 is the average sales price (ASP) + 6 percent.

CMS is allowing pass-through status to expire for nine drugs and biologicals, listed in table 28, and is continuing pass-through status for 35 others, shown in table 29 of the *Federal Register*.

**Payment for Medical Devices with Pass-Through Status**
*Federal Register* pages 66870-66872

The only medical device that is currently provided pass-through payment status is HCPCS code C1841 (Retinal prosthesis, includes all internal and external components). CY2015 will be the last year of pass-through status for this device; beginning in CY2016, payments for these devices will be packaged with related procedures.

**Payment Adjustment for No Cost/Full Credit and Partial Credit Devices**
*Federal Register* pages 66872-66873

For outpatient services that include certain medical devices, CMS reduces the APC payment if the hospital received a credit from the manufacturer. The offset can be 100 percent of the device amount when a hospital obtains the device at no cost or receives a full credit from the manufacturer, or 50 percent when a hospital receives partial credit of 50 percent or more.

For CY2015, hospitals must continue to report any credits received if they are 50 percent or more of the cost of the device. CMS has updated the lists of APCs and devices to which the no cost/full credit and partial credit payment policy apply in CY2015. The lists are available in Tables 26 and 27 on page 66873 of the *Federal Register*.

## OTHER OPPS POLICIES

**New Data Collection for Services in Provider-Based Outpatient Clinics**
*Federal Register* pages 66910-66914

CMS will begin to collect data on the type and frequency of physician services provided in HOPDs, free-standing clinics or doctor's offices, and off-campus provider-based clinics. Currently, CMS does not have access to data that differentiates between services provided in these settings. CMS cites the growing trend in hospitals' acquisition of physician offices and how those locations are then considered off-campus provider-based departments for reimbursement purposes. The current reimbursement differential between the settings is the rationale for this data collection.

To implement this new data collection policy, CMS is creating a HCPCS modifier to be reported with every code for outpatient hospital services (UB-04 form). The reporting will be voluntary in CY2015 and become mandatory in CY2016. For physicians' services furnished in an off-campus setting (CMS-1500 claim form), CMS will be deleting the current place of service (POS) code 22 (outpatient hospital department) and establishing two new POS codes – one to identify outpatient services furnished in on-campus, remote, or satellite locations of a hospital, and one to identify services furnished in an off-campus provider-based department of hospitals. These new POS codes will be required to be reported as soon as they become available."

**Updates to the Inpatient List**
*Federal Register* page 66909-66910

The inpatient list specifies services/procedures that Medicare will only pay for when provided in an inpatient setting. For CY2015, CMS is adding one service to the inpatient list: (CPT code 22222: Osteotomy of spine, including discectomy, anterior approach, single vertebral segment, thoracic). The list of inpatient only procedures is available in Addendum E.

**Partial Hospitalization Program (PHP) Services**
*Federal Register* pages 66900-66908

The PHP is an intensive outpatient psychiatric program to provide outpatient services in place of inpatient psychiatric care. PHP services may be provided in either a hospital outpatient setting or a freestanding Community Mental Health Center (CMHC). PHP providers are paid on a per diem basis with payment rates calculated using CMHC- or hospital-specific data. The table below compares the CY2014 and CY2015 PHP payment rates.

| APC | Group Title | CY2014 Payment Rate | CY2015 Payment Rate | Percent Change |
|---|---|---|---|---|
| 0175 | Hospital-Based PHPs-Level I PHP (three services) | $190.15 | $179.11 | -5.8 |
| 0176 | Hospital-Based PHPs-Level II PHP (four or more) | $213.64 | $195.62 | -8.4 |
| 0172 | CMHCs-Level I PHP (three services) | $99.04 | $96.51 | -2.6 |
| 0173 | CMHCs-Level II PHP (four or more) | $111.73 | $114.23 | +2.2 |

For CMHCs, for APC 0173, CMS will continue to make outlier payments for 50 percent of the amount by which the cost for the PHP service exceeds 3.4 times the payment rate.

**Updates to the Hospital Outpatient Quality Reporting (OQR) Program**
*Federal Register* pages 66940-66966

The OQR program is mandated by law; hospitals that do not successfully participate are subject to a 2.0 percentage point reduction to the OPPS market basket update for the applicable year. The required OQR measures for CY2015 payment determinations were established in prior years' rulemaking and the 23 required quality measures are listed in the final CY2014 *Federal Register* (page 75095).

A table that lists the 27 measures CMS is currently collecting for CY2016 payment determinations is available on page 66944 of the final rule *Federal Register*.

The final CY2015 OPPS rule establishes the OQR program changes for CY2017 payment determinations. CMS will require successful reporting of data on a total of 26 quality measures in total. The changes from the CY2016 measure are as follows:

Elimination of two chart-abstracted process measures:

- OP-6 – Timing of Antibiotic Prophylaxis; and
- OP-7 – Prophylactic Antibiotic Selection for Surgical Patients.

Addition of one new claims-based outcomes measure:

- OP-32 – Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy. This measure would evaluate all-cause/unplanned hospital visits (admissions, observation stays, and emergency department visits) within seven days of an outpatient colonoscopy procedure.

CMS has finalized its proposal to allow for voluntary reporting of OP-31: Cataracts – Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery.

**Physician Certification Requirements**
*Federal Register* pages 66997-66999

The Social Security Act states that Medicare Part A payments can only be made for services "*which are furnished over a period of time, if a physician certifies that such services are required to be given on an inpatient basis*." CMS has interpreted "over a period of time" as requiring physician certification for <u>all</u> inpatient admissions. The hospitals have argued that the law and regulations lack a specific deadline for physician certification in non-outlier cases, suggesting that it should only apply to certain long-term stays.

In this final CY2015 OPPS rule, CMS is revising its regulations such that physician recertification will only be required for inpatient hospital stays (not including inpatient psychiatric facility services) that extend for 20 days or more, or are considered outlier cases. The finalized physician certification must include the following:

- *"The reasons for either:*
    - *Continued hospitalization of the patient for medical treatment or medically required diagnostic study; or*
    - *Special or unusual services for cost outlier cases.*
- *The estimated time the patient will need to remain in the hospital.*
- *The plans for post hospital care, if appropriate."*

**Exceptions to the Physician Self-Referral Law**
*Federal Register* pages 66989-66997

The PPACA imposed limitations that prohibit physician-owned hospitals from expanding capacity. There is a process that allows high-Medicaid providers to apply for an exception to the expansion limitation based on volume data from the Healthcare Cost Report Information System (HCRIS) for Medicaid and Medicaid managed care.

In the final CY2015 OPPS rule, CMS confirms the feedback it has received from hospitals that HCRIS does not include data on Medicaid managed care admissions and discharges. To assist those physician-owned hospitals that have been unable to satisfy the current expansion exception requirements using HCRIS data, CMS is adopting the following policies:

- *"the use of external data sources to estimate a physician-owned hospital's annual percentage of inpatient admissions under Medicaid . . . the average percentage of inpatient admissions under Medicaid of all hospitals in the county in which a physician-owned hospital . . . is located . . . and the annual percentage of inpatient admissions under Medicaid of any other hospital in the county in which a physician-owned hospital requesting an expansion exception as a 'high Medicaid facility' is located . . . . However, on or after such date that the Secretary determines that HCRIS contains sufficiently complete inpatient Medicaid discharge data, a hospital may use only filed Medicare hospital cost report data to estimate the percentages of inpatient Medicaid admissions . . . .;*
- *defining 'external data source' . . . to mean a data source that (1) is generated, maintained, or under the control of a State Medicaid agency; (2) is reliable and transparent; (3) maintains data that, for purposes of the process described . . ., are readily available and accessible to the requesting hospital, comparison hospitals, and CMS; and (4) maintains or generates data that, for purposes of the process described . . ., are accurate, complete, and objectively verifiable."*

- Requiring a requesting physician-owned hospital to satisfy the criterion during the most recent fiscal year for which HCRIS contains data from a sufficient number of hospitals to determine:

    - State's average bed capacity and the national average bed capacity.
    - Hospital's average bed occupancy rate and the relevant State's average bed occupancy rate.