AMERICAN ACADEMY OF OTOLARYNGOLOGY– HEAD AND NECK SURGERY

# AAO-HNS SUMMARY OF THE FINAL HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS) FOR CY 2014

On November 27, the Centers for Medicare & Medicaid Services (CMS) released its final rule for Medicare's hospital outpatient prospective payment system (OPPS) and ambulatory surgical center (ASC) payment system. The Academy will submit comments to CMS on the OPPS/ASC final rule by the January 27, 2014 deadline.

**Background on the OPPS:** The OPPS payments cover facility resources including equipment, supplies, and hospital staff, but do not pay for the services of physicians and non-physician practitioners who are paid separately under the Medicare Physician Fee Schedule (MPFS). All services under the OPPS are technical and are classified into groups called Ambulatory Payment Classifications (APCs). Services in each APC are grouped by clinically similar services that require the use of similar resources. A payment rate is established for each APC using two year old hospital claims data adjusted by individual hospitals cost to charge ratios. The APC national payment rates are adjusted for geographic cost differences, and payment rates and policies are updated annually through rulemaking.

## Important 2014 Otolaryngology- Head and Neck Surgery policies in the OPPS Setting:

### 1. OPPS 2014 Proposed Payment Rates:

For CY 2014, CMS finalizes a hospital outpatient department conversion factor of $71.219. This is based on a hospital inpatient market basket rate increase of 2.5% minus the proposed multifactor productivity (MFP) adjustment of -.5%, and the -.3% adjustment, which are both required under the Affordable Care Act (ACA). CMS has also proposed to continue implementing the statutory 2% reduction in payments for hospitals who fail to meet the hospital outpatient quality reporting (OQR) requirements.

### 2. Updates Affecting OPPS Payments:

In CY 2014, CMS has continued the changes made in 2013 to base the relative weights on geometric mean costs rather than previously utilized median costs. It will continue to use these weights to set a cost to charge ratio within an APC to determine payment for services within an APC. In CY 2014, CMS finalizes several significant changes to their methodology to calculate APC payments, including:

- greatly expanding the types of services that are packaged and not paid separately;
- replacing the current five levels of visit codes for clinic visits with a single new alphanumeric Level II HCPCS code representing **one level of payment for all clinic visits**; the final rule maintains current codes for Type A emergency department (ED) and Type B ED visits;
- using distinct cost-to-charge ratios (CCRs) for cardiac catheterization, CT scan, and MRI to calculate the relative payment weights; and
- effective January 1, 2015, **establishing comprehensive APCs for 29 device-dependent services and make a single payment for the comprehensive service based on all OPPS-payable charges on the claim**.

Impacts to Otolaryngology related to these key policy changes is outlined below. To see a complete list of APCs and the impact on their payment rates, click *here*.

### CMS' Proposed Changes to Packaging Rules in CY 2014

**Background:** Beginning in 2008, CMS extended packaging to seven additional categories: guidance services, image processing services, intraoperative services, imaging supervision and interpretation, observation services, diagnostic radiopharmaceuticals and contrast media. ***Payment for these items or services is packaged into the payment for the primary diagnostic or therapeutic service with which they are billed and to which CMS believes they are typically ancillary and supportive.*** For 2014, CMS proposed to expand packaging to several additional types of items and services, noting their goal to make the OPPS more like a prospective payment system and less a fee schedule. CMS believes prospective payment enhances incentives for hospitals to furnish services in the most efficient way, by enabling them to manage their resources with maximum flexibility, thereby encouraging long-term cost containment. Within the seven categories packaged in 2013, the costs of some services are unconditionally packaged into the costs of the separately paid

primary services with which they are billed; CMS believes that they are always integral to the performance of the primary modality.

***New Packaging Policies for CY 2014***

For CY 2014, CMS finalizes the addition of five items (four of which are relevant to ENTs) and services to those that will be packaged under the OPPS. The packaging policies which impact Otolaryngology are discussed in greater detail below. ***Of note, these policies impact a number of ENT services, including laryngology procedures, head and neck imaging services, audiology, and SLP services.*** For information on specific CPT codes impacted, access the links included in the discussions of each packaging policy below.

***1. Drugs and Biologicals That Function as Supplies or Devices When Used in a Surgical Procedure***

The OPPS has packaged medical devices, medical and surgical supplies, and surgical dressings into the related procedure since its inception. ***For 2014, CMS expands the existing packaging policy for implantable biologicals to unconditionally package all drugs and biologicals that function as supplies or devices in a surgical procedure. This affects skin substitutes***, which CMS believes do not function like human skin that is grafted onto a wound; rather, they stimulate the host to regenerate lost tissue and replace the wound with functional skin. Skin substitutes are applied to a wound during a surgical procedure described by CPT codes in the range 15271 through 15278.

CMS feels that because a skin substitute must be used to perform any of the procedures described by a CPT code in the range 15271 through 15278, and because it is the surgical procedure of treating the wound and applying a covering to the wound that is the independent service, skin substitute products serve as a necessary supply for these surgical repair procedures and should be UNCONDITIONALLY packaged. CMS observes that packaging payment for these skin substitutes into the APC payment would result in a total payment that is more reflective of the average resource costs of the procedures because prices for these products vary significantly from product to product. In the final rule CMS divides skin substitutes into two groups for packaging purposes, high cost skin substitutes and low cost skin substitutes.

***2. Clinical Diagnostic Laboratory Tests***

In 2013, laboratory tests provided in the hospital outpatient setting were paid at Clinical Laboratory Fee Schedule (CLFS) rates. For 2014, ***CMS concludes that that laboratory and diagnostic tests (other than molecular pathology tests) should be packaged when they are integral, ancillary, supportive, dependent, or adjunctive to a primary service or services provided in the hospital outpatient setting.*** Laboratory tests would be **considered integral, ancillary, supportive, dependent, or adjunctive to a primary service or services provided in the hospital outpatient setting when** *they are provided on the same date of service as the primary service and when they are ordered by the same practitioner who ordered the primary service.* Tests would **not be packaged when** *the test is the only service provided on that date of service, or when the test is provided 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.*

***3. Procedures Described By Add-On Codes***

Add-on codes describe procedures that are always performed in addition to a primary procedure. Currently, add-on codes typically receive separate payment based on an APC assignment, and usually are assigned status indicator "T." ***Because add-on codes represent an extension or continuation of a primary procedure, they are typically supportive, dependent, or adjunctive to a primary surgical procedure, CMS finalizes their policy to unconditionally package all procedures described by add-on codes in the OPPS in CY 2014***. For a list of impacted services, click here.

*4.* ***Device Removal Procedures***

Within the final rule CMS finalizes their proposal to package device removal procedures as part of an overall procedure when it is performed with a separately coded device repair or replacement procedure. They believe the device removal is a service that is integral and supportive to a primary service and therefore, should be conditionally packaged when billed with other surgical procedures involving repair or replacement.

**New Comprehensive APC's**

In an effort to improve accuracy and transparency of certain device dependent procedures, CMS finalizes 29 new comprehensive APC's to prospectively pay for the most costly device dependent services and replace 29 of the most costly device-dependent APC's. ***A comprehensive APC is defined to include the provision of a primary service and all adjunctive services provided to support the delivery of the primary service. Under the comprehensive APC, the entire***

***claim, including the primary service, is associated with a single comprehensive service and all costs reported on the claim would be assigned to that service.*** The comprehensive APC treats all individually reported codes as representing components of the comprehensive service and would make a single payment based on the cost of all individually reported codes, representing provision of the primary service, as well as all adjunctive services provided to support delivery of the primary service. CMS believes this will increase the accuracy of the payment for the comprehensive service and also increase the stability of the payment from year to year. ***Of note, APC 0259 (Level VII ENT Procedures) will be included as a comprehensive APC.***

***Changes to APC Assignments Affecting Head and Neck Surgery***

Within the final rule, CMS makes several changes to APC assignments for Otolaryngology services, including assigning new CPT code 64617 **Chemodenervation of Larynx t**o APC 0206 with a 2014 APC payment rate of $353.99. Further, CMS modifies the APC assignment of CPT 31571 **Direct Laryngoscopy** from APC 0075 to 0074, representing a change in reimbursement from $2026.82 in 2013 to $1880.43 in 2014. Similarly, CMS modified APC assignments for **Balloon Sinus Codes** CPT 31295 and 31296 to assign them to APC 0075 in CY 2014 and for 31297 and 31541 from APC 0075 to 0074 for 2014. This results in a change in payment for 31295 and 31296 from $2026.82 in 2013 to $3051.76 in 2014 and from $2026.82 in 2013 for CPT 31297 and 31541 to $1880.43 in CY 2014.

**OPPS Payment for Hospital Outpatient Visits**

For CY 2014, CMS establishes a single visit code for hospital clinics, replacing the five visit levels used in the OPPS since 2007. The mid-level clinic visit, APC 606, has been the most frequently used outpatient hospital visit code. Under the final rule, the new single level clinic visit, APC 0634, would have a base payment rate of $92.53 in 2014, a reduction of about 4.6 percent compared to the current payment rate of $96.96 for the mid-level clinic visit (APC 606). They believe a policy that recognizes a single visit level for clinic visits under the OPPS is appropriate for several reasons, including:

- The policy is in line with their goal of using larger payment bundles to maximize hospitals' incentives to provide care in the most efficient manner.
- The policy will remove any incentives hospitals may have to provide medically unnecessary services or expend additional, unnecessary resources to achieve a higher level of visit payment under the OPPS.
- The policy will reduce hospitals' administrative burden by eliminating the need for them to develop and apply their own internal guidelines to differentiate among five levels of resource use for every clinic visit they provide, and by ***eliminating the need to distinguish between new and established patients.***
- Lastly, they believe that removing the differentiation among five levels of intensity for each visit will eliminate any incentive for hospitals to "upcode" patients whose visits do not fall clearly into one category or another.

The proposed new visit coding structure is outlined below:

| Visit Type | CY 2013 | | Proposed CY 2014 | |
|---|---|---|---|---|
| | HCPCS | APC | NEW HCPCS | NEW APC |
| **Clinic Visit** | 99201 | 0604 | **G0463** | **0634** |
| | 99202 | 0605 | | |
| | 99203 | 0606 | | |
| | 99204 | 0607 | | |
| | 99205 | 0608 | | |
| | 99211 | 0604 | | |
| | 99212 | 0605 | | |
| | 99213 | 0605 | | |
| | 99214 | 0606 | | |
| | 99215 | 0607 | | |

**3. OPPS Payment Changes for Drugs Biologicals:**

***Separately Payable Drugs and Biologicals:*** CMS currently pays separately for drugs, biological, and radiopharmaceuticals that do not have pass-through status in one of two ways; they either package them into the payment for the procedure, or pay for the drug separately. A separate payment is rendered when the cost of the drug or biological

exceeds the packaging dollar threshold amount set annually by CMS. CMS will **pay for separately payable drugs at the statutory default rate of Average Sales Price (ASP) + 6% in 2014.** This rate makes payment in the MPFS commensurate to the OPPS for drugs and biologicals and is consistent with their policies in 2013.

***Payment for Packaged Drugs and Biologicals:*** For CY 2014, CMS has increased the packaging threshold to $90 per day from the $80/day threshold in 2013. If a drug exceeds this $90 threshold and does not have pass-through status, separate payment is provided at the ASP + 6% methodology explained above. All drugs costing less than $90/day are packaged into the payment for the procedure and one payment is made for the cost of the procedure + the drug/biological used during the procedure.

## 4. Clarification of Supervision Requirements in the OPPS:

***Supervision of Outpatient Therapeutic Services in CAHs and Small Rural Hospitals***
CMS ends its non-enforcement policy requiring direct supervision of outpatient therapeutic services in CAHs and small rural hospitals; thus, for years beginning with 2014, CAHs and small rural hospitals have to comply with the CMS supervision policy which requires direct supervision of therapeutic services, except for those that CMS identifies as appropriate for general supervision. CMS believes that it is appropriate to let this grace period expire to ensure the quality and safety of hospital and CAH outpatient therapeutic services provided by Medicare.

***Supervision for Observation Services***
In addition CMS clarified that for observation services, if the supervising physician or appropriate nonphysician practitioner determines and documents in the medical record that the beneficiary is stable and may be transitioned to general supervision, general supervision may be furnished for the duration of the service. Medicare does not require an additional initiation period(s) of direct supervision during the service. CMS believes that this clarification will assist hospitals in furnishing the required supervision of observation services without undue burden on their staff.

## 5. Hospital Outpatient Quality Reporting (OQR) Program:

***Quality Program Penalty:*** As established in previous rules, **hospitals will continue to face a 2% reduction to their OPD fee schedule update for failure to report on quality measures in the OQR Program in CY 2014**.
Program measures and details on timing and reporting periods can be accessed at:
https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1191255879384.

***Changes to Measures for 2014:*** For 2014 reporting, CMS adds 4 new quality measures and removes 2 measures from the OQR program for CY 2016 payment. None of the four new measures are applicable to our specialty; however, one of the two measures proposed for deletion (Transition Record with Specified Elements Received by Discharged Patients) may have been reportable by ENTs. CMS states their intent to delete that measure is due to their inability to implement the measure with the necessary degree of specificity without being overly burdensome to stakeholders.

***Electronic Health Records:*** CMS reiterates its intention that the hospital OQR program will transition to the use of certified EHR technology for submission of data on those measures that require information from the clinical record. CMS estimates this transition will occur sometime after 2015, and notes much work remains to reach this point, including developing electronic specifications, pilot testing, reliability and validity testing, etc.

**Additional Resources:** To access the full final rule for CY 2014 click:
http://www.ofr.gov/(X(1)S(vp32o25ckyhpvspfpzx3owe4))/OFRUpload/OFRData/2013-28737_PI.pdf.

.