

AAO-HNS SUMMARY OF THE PROPOSED HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS) AND AMBULATORY SURGICAL CENTER (ASC) PAYMENT SYSTEMS FOR CY 2013

On July 6th the Centers for Medicare and Medicaid Services (CMS) released its proposed rule for Medicare's hospital outpatient prospective payment system (OPPS) and ambulatory surgical center (ASC) payment system. The Academy is providing this summary in response to an increased number of Members who indicate they practice in hospital outpatient or ASC settings. The Academy will submit comments to CMS on the MPFS proposed rule by the **September 4, 2012 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.

Background on ASCs:

CMS performs an annual review of the legislative history and regulatory policies regarding changes to the lists of codes and payment rates for covered surgical procedures and covered ancillary services in an Ambulatory Surgical Center (ASC) setting. Covered surgical procedures in the ASC setting are defined as procedures that would not be expected to pose a significant risk to beneficiary's safety when performed in an ASC and that would not be expected to require active medical monitoring and care at midnight following the procedure. CMS reviews the ASC payment system to implement applicable statutory requirements and changes arising from continuing experience with this system. In the proposed rule, CMS proposes relative payment weights and payment amounts for services furnished in ASCs, and other rate setting information for the CY 2012 ASC payment system.

Important Otolaryngology- Head and Neck Surgery policies addressed by CMS for the Hospital Outpatient Setting:

1. OPPS 2013 Proposed Payment Rates:

For CY 2013, CMS proposes a hospital outpatient department conversion factor rate increase of 2.1%. This is based on a hospital market basket rate increase of 3% minus the proposed multifactor productivity (MFP) adjustment of -.8%, and the -.1% 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 2013, CMS has proposed using the geometric mean cost of services within an Ambulatory Payment Classification (APC) to determine relative payment weights for services. This is a drastic change from the former methodology, used since the inception of the OPPS in 2000, which relied on the median costs of services to establish relative weights for services. CMS states that this change is in response to commenter's persistent concerns regarding the degree to which payment rates reflect the costs associated with providing a service, year to year variation, and whether packaged items are appropriately reflected in payment weights. In addition, the Agency felt that the mean better encompasses the variation in costs and the range of costs associated with providing services. It also will allow earlier detection of changes in the cost of services and may promote better stability in the payment system. Further, this brings the OPPS in line with the inpatient methodology which uses mean costs to calculate the diagnosis related group (DRG) weights. Last, CMS believes this will improve their ability to identify resource distinctions between previously homogeneous services.

For Otolaryngology-Head and Neck Surgery, this will have differing effects on reimbursement that varies by APC. Some APCs will see increases ranging from 1 – 4 percent while other APCs will see reductions in payment of over 10 percent in 2013. This trend is mirrored across specialties and APCs, resulting in some services benefiting from the policy change whereas others do not. To see a complete list of APCs and the impact on their payment rates, click [here](#).

New Cost Centers for 2013 / Calculation of Cost to Charge (CCR) Ratios:

CMS also proposes to incorporate a new, separate cost center for implantable devices. Similarly, separate cost centers have been created for CT scans, MRIs, and cardiac catheterization beginning on or after May 1, 2010. CMS expects to have cost report data available for creating these distinct CCRs for the 2014 OPPS rulemaking. The impact of this policy change is that several APC costs were reduced, which will result in a reduction in the APC's overall payment rate for 2013. Some of the most impacted

APCs include APC 12 (Level I Debridement and Destruction) which declined -8.15%, and APC 251 (Level II ENT procedures) which fell -8.46%.

3. OPSS 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. For drugs separately payable in 2013, CMS proposes abandonment of the standard rate setting methodology and instead, proposes to **pay separately payable drugs at the statutory default rate of Average Sales Price (ASP) + 6%**. This is a significant increase from the 2012 payment of ASP+4% and will now make payment in the MPFS commensurate to the OPSS for drugs and biologicals.

Payment for Packaged Drugs and Biologicals:

In 2013, CMS sets the packaging threshold for drugs and biological at \$80 per day. If a drug exceeds this \$80 threshold and does not have pass-through status, separate payment is provided at the ASP + 6% methodology explained previously. All drugs costing less than \$80/day are packaged into the payment for the procedure and only one payment is provided for the packaged cost of the procedure + the drug/biological used during the procedure. This threshold is an increase from the \$75/day threshold used in 2012.

4. OPSS Payment for Hospital Outpatient Visits

Hospital Outpatient Visit Policies:

Currently, hospitals report HCPCS visit codes to describe three types of OPSS services: clinic visits, emergency department visits, and critical care services, including trauma team activation. For CY 2013, CMS is proposing to continue to recognize these CPT and HCPCS codes describing clinic visits, Type A and Type B emergency department visits, and critical care services. (Listed in Table 29 of the proposed rule).

CMS also proposes to continue to recognize existing CPT codes for critical care services; to set payment rate based on historical data; and to package the costs of care and ancillary services, despite AMA CPT Editorial Panel policy which requires hospitals to report ancillary services and associated charges separately. CMS states their continued belief, based on 2011 hospital claims data, that hospitals have not changed their billing practices for CPT code 99291 and therefore, separate payment for these ancillary services is inappropriate. As a result, they will continue to utilize a claims processing edit that packages payment for ancillary services provided on the same date of service as critical care services. CMS states they will continue to monitor this policy for potential revisions in the future.

Hospital Observation Status Policy:

Under current policy, when a Medicare beneficiary presents to the hospital for care the physician must decide whether to admit them as an inpatient or treat them as an outpatient. Inpatient services are paid under Medicare Part A, while outpatient services are paid under Medicare Part B. Occasionally, when a physician admits the patient for inpatient care, a reviewing body such as a MAC, RAC, or CERT will review the claim and deny it as not reasonable and necessary under the Social Security Act (SSA). In these cases, hospitals may rebill a new inpatient claim for a limited set of Part B services that were furnished to the patient and refer to it as "Inpatient Part B" or "Part B Only" services. They may also bill Medicare Part B for any outpatient services that were provided to the patient during the 3-day payment window prior to the admission of the patient.

Once the patient is discharged, however, the hospital cannot change their status to outpatient in order to submit an outpatient claim. If they wish to change the status, it must be done prior to discharge and the patient, provider, and utilization review committee must agree with the status change decision. The reason for this restriction is due to potential liability for the beneficiary. Specifically, beneficiary's that are admitted as inpatients pay a onetime deductible for all services provided during their first 60 days in the hospital. They are not asked to pay for self-administered drugs and post-acute skilled nursing facility (SNF) care that may be required is covered by Medicare, so long as the beneficiary was in the hospital as an inpatient for 3 days. Outpatients, however, are required to pay a copayment for each individual's outpatient service and self-administered drugs and SNF care are not covered by Medicare Part B.

CMS seeks comment on ways to better address consistent areas of concern regarding these policies which are frequently raised by stakeholders during the annual rulemaking process. Specifically, CMS notes that from 2006 to 2010 the number of Medicare beneficiaries receiving observation services (in the outpatient setting) for more than 48 hours has increased from 3% to 7.5%. They note that this could have significant financial implications for Medicare beneficiaries being treated as outpatients rather than

being admitted. In contrast, hospitals have expressed concern that paying less for hospital observation services results in inadequate payment for resources required to provide necessary care. Further, hospitals have expressed concern that they do not always have necessary staff on hand after normal business hours to confirm the physician's decision to admit the beneficiary, so they may be unable to change the patient's status prior to discharge, as required under current rules.

In the CY 2013 rule, CMS has asked the public to comment on the following items related to this issue:

how they might improve current instructions on when a patient should be admitted as an inpatient,

- whether it is permissible for them to redefine "inpatient" using length of stay or other variables as the parameters in conjunction with medical necessity,
- whether it is appropriate or useful to establish a point in time after which an encounter becomes an inpatient stay,
- whether they should cap the amount of time a beneficiary can receive observation services as an outpatient, and
- whether the use of clinical measures or prior authorization would be useful requirements for payment of an admission.

Transitional Care Management:

As part of a prolonged strategy to encourage coordination between primary care and specialists for beneficiaries, CMS proposes within the 2013 Medicare Physician Fee Schedule (MPFS) to create a HCPCS G-code for care management transitions furnished by a physician during a hospital or SNF stay to care furnished in the community by the beneficiary's physician or qualified non-physician practitioner. This is intended to address the non-face-to-face work involved in discharge care coordination by clinical staff or office-based managers. This G code will be assigned a status indicator "N" which indicates these services are PACKAGED with the payment for the primary service furnished in the hospital outpatient setting.

5. Clarification of Supervision Requirements in the OPPTS:

Conditions of Payment for Therapy services in Hospitals and CAHs

In response to concerns expressed in past years' MPFS public comments, CMS clarifies that it does not intend to establish different supervision requirements for hospitals and critical access hospitals (CAHs) under §410.27 of the regulations for physical therapy, speech language pathology, and occupational therapy services provided in the outpatient setting when furnished under a certified therapy plan of care. CMS notes that if the services are billed by the hospital or CAH as therapy services, the supervision requirements do not apply. However, CMS notes that policies covered by §410.27, of the Medicare coverage manual, regarding supervision and other requirements do apply to PT, SLP, and OT services when those services are not furnished under a certified therapy plan of care (referred to as "sometimes therapy" services).

Supervision of Outpatient Therapeutic Services in CAHs and Small Rural Hospitals

For CY 2013, CMS is proposing another 1 year extension of its policy of "non-enforcement" of the direct supervision requirement for outpatient therapeutic services. This exception only applies to critical access hospitals (CAHs) and small rural hospitals through 2013. The Agency notes that this will likely be the last year of this extended policy. Hospitals that believe this policy applies to them must identify for CMS any services for which they anticipate difficulty in complying with the direct supervision requirements in 2013. CMS will then present those services to the Advisory Panel (APC Panel) for potential changes to the minimum supervision levels.

6. Hospital Outpatient Quality Reporting (OQR) Program:

- **Quality Program Penalty:** As established in previous rules, **hospitals will continue to face a 2 percentage point reduction to their OPD fee schedule update for failure to report on quality measures in the OQR Program.** Program measures can be accessed at: www.QualityNet.org.
- **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.
- **2013 Measure EHR Incentive Program:** CMS proposes to continue, in 2013, the Electronic Reporting Pilot that was finalized for 2012. Regulations would be revised to reflect continuation of the program and to conform to proposed changes included in the EHR Incentive Program Stage 2 proposed rule. Under this program, eligible hospitals and CAHs could continue to report clinical quality measure results by attestation under the Medicare EHR Incentive Program.

Important CMS policies Impacting Otolaryngology- Head and Neck Surgery In the ASC setting:

1. ASC 2013 Proposed Payment Rates:

For CY 2013, CMS proposes a 1.3% increase to the ASC conversion factor - or the updated consumer price index (CPI-U) (a consumer price index for all urban consumers), minus the projected multifactor productivity adjustment of 0.9% required by the ACA. This results in a proposed increase in the conversion factor from \$42.627 in 2012 to \$43.190 in 2013. The table below reflects the major categories of procedures in the ASC setting, the amount paid to each of those settings in 2012, and the estimated percentage change in payments to those categories for 2013. Of note, Otolaryngology procedures fall within several of the key categories, including Eye, Integumentary, Auditory, Lymphatic, etc.

Surgical Specialty Group	Estimated 2012 ACS Payments (in Millions)	Estimated 2013 Percent Change
Total	\$3,430	1%
Eye and ocular adnexa	\$1,448	1%
Digestive system	\$715	3%
Nervous system	\$436	5%
Musculoskeletal system	\$430	-1%
Genitourinary system	\$159	0%
Integumentary system	\$129	-2%
Respiratory system	\$45	-2%
Cardiovascular system	\$31	-2%
Ancillary items and services	\$21	0%
Auditory system	\$11	1%
Hematologic & lymphatic systems	\$5	0%

Surgical Procedures Designated as Office Based

Annually, CMS proposes to update payments for office-based procedures and device-intensive procedures using its previously established methodology. Office-based procedures are defined as surgical procedures which are utilized more than 50% in the physicians' office. **For CY 2013, CMS is proposing, based on their review of CY 2011 utilization data, to PERMANENTLY designate six covered surgical procedures as "office based" within the ASC setting. Most notably, three of those codes are Nasal/Sinus endoscopy procedures (CPT codes 31295, 31296, and 31297).** This means that CMS will pay for these procedures at the **lesser of** the proposed 2013 MPFS non-facility Practice Expense (PE) RVU amount, or the proposed 2013 ASC payment amount.

Payment for Device-Intensive Procedures in the ASC Setting:

CMS proposes adoption of the OPPS policy related to full benefit / full cost devices. This applies when the ASC receives the device without cost or with full (FB) or partial (FC) credit from the manufacturer. CMS is proposing an update to the ASC list of covered surgical procedures that are eligible for payment according to device-intensive procedure payment methodology, consistent with the proposed OPPS device dependent APC update. **Notably, CPT 69930, implantation of cochlear devices is one of the services for for which this policy would apply in CY 2013.** The Agency has also proposed a list of specific devices for which the FB or FC modifier MUST be reported when the device is furnished at no cost (FB) or with full or partial credit (FC). **Relevant codes for Otolaryngology include: L8614 (cochlear device/system); L8680, 85, 86, 87, 88 (Implant neurostimulators- 5 codes); and L8690 (Auditory osseo dev, int/ext comp).**

2. ASC Quality Reporting Program:

- **Quality Program:** In 2012, CMS finalized the implementation of an ASC quality reporting program (ASCQR) which will begin with 2014 payment determination. Quality measures have been adopted for the calendar years (2014-2016). The measures can be found at: www.Qualitynet.org.
- **Effective Date:** **CMS proposes that BEGINNING OCTOBER 2012, ASCs will be expected to report claims-based measures which will be used to calculate 2014 payment.** Similarly, data reported in 2013 will be used to calculate payment in 2015. ASCs must submit data on the claims-based quality measures by including the appropriate Quality Data Code (QDC) on their Medicare claims.
- **Payment reductions:** In this rule, CMS proposes implementation of the ASCQR program which will include the **2% payment reduction for ASCs who fail to properly report their quality data.**

- 3. Additional Resources:** To access the full proposed rule for CY 2013 click: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1589-P.html>. If your facility or state Otolaryngology society is interested in submitting comments, the electronic submissions of comment can be made at URL: www.Regulations.gov search for CMS and final rules.