

## **AAO-HNS SUMMARY OF THE PROPOSED HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS) AND AMBULATORY SURGICAL CENTER (ASC) PAYMENT SYSTEMS FOR CY 2014**

On July 8<sup>th</sup> 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 will submit comments to CMS on the OPPS/ASC proposed rule by the September 6, 2013 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 proposes a hospital outpatient department conversion factor rate increase of 1.8%. This is based on a hospital inpatient market basket rate increase of 2.5% minus the proposed multifactor productivity (MFP) adjustment of -.4%, 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. *Click [here](#) to access a summary of changes in reimbursement under the proposed rule for CY 2014 for the 100 most frequently billed ENT services in the OPPS setting.*

#### **2. Updates Affecting OPPS Payments:**

In CY 2014, CMS has proposed to continue 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 proposes four significant changes to their methodology to calculate APC payments, including:

- Extensive changes to the types of services that are packaged and, if finalized, will no longer be paid separately;
- Establishing comprehensive APCs for 38 device-dependent services and applying a single payment for the comprehensive service based on all OPPS payable charges on the claim;
- Using distinct cost-to-charge ratios (CCRs) for CT and MRI scans to calculate payment weights; and
- Replacing the current five levels of visit codes for the clinic with three new Level II HCPCS codes which represent a single level of payment for each of the three visit types

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 proposes 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.

### Proposed New Packaging Policies for CY 2014

For CY 2014, CMS proposes to add the five items (four of which are relevant to ENTs) and services to those that will be packaged under the OPSS. 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 OPSS has packaged medical devices, medical and surgical [supplies](#), and surgical dressings into the related procedure since its inception. ***For 2014, CMS proposes to expand 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 proposed policy would affect [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.

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

In 2013, laboratory tests provided in the hospital outpatient setting continue to be paid separately to hospitals at Clinical Laboratory Fee Schedule (CLFS) rates. ***CMS proposes to change this policy for 2014, concluding that that laboratory 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.**

Another impact of this proposed policy relates to beneficiary coinsurance. While the Medicare Part B deductible and coinsurance generally do not apply for laboratory tests paid to hospitals currently, ***they would apply to laboratory tests packaged into other services in the OPSS. The agency invites public comments on the effect of packaging laboratory tests on beneficiary coinsurance.*** Click the following links for a list of impacted [diagnostic](#) and [laboratory](#) tests.

#### **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 proposes to unconditionally package all procedures described by add-on codes in the OPSS in CY 2014.*** For a list of impacted services, click [here](#).

#### **4. Ancillary Services (Status Indicator "X")**

The OPSS currently makes a separate payment for certain ancillary services that are assigned status indicator "X," defined as "ancillary services." Some other services that are ancillary to other services are currently packaged in the OPSS. CMS notes that even those ancillary services assigned status indicator "X" and paid separately are, by definition, ancillary relative to primary services provided in the OPSS. Given its goal to strengthen the prospective payment aspects of the OPSS by packaging services that are integral, ancillary, supportive, dependent, or adjunctive to a primary service, ***CMS proposes to package these ancillary services when they are performed with another service and to continue to pay separately when performed alone.*** Thus, the proposed rule would ***conditionally package*** all ancillary services that were previously assigned a status indicator of "X" and assign these services to status indicator "Q1" (packaged when provided

with a service assigned a status indicator of “S,” “T,” or “V”). Status indicator “X” would be discontinued. ***This policy directly impacts several ENT services, including some laryngology codes, x-ray services performed on the head and neck region, and audiology services. For specific codes impacted, click [here](#).***

#### **Future Packaging for Imaging Services under Consideration**

CMS indicates that it is considering a proposal for 2015 that would conditionally package all imaging services with any associated surgical procedures. Imaging services not provided with a surgical procedure would continue to either be separately paid according to a standard clinical APC or a composite APC. **CMS requests public comments on this potential CY 2015 proposal.**

#### **New Comprehensive APC's**

In an effort to improve accuracy and transparency of certain device dependent procedures, CMS proposes 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 would be defined to include the provision of a primary service and all adjunctive services provided to support the delivery of the primary service. Under the proposal, the entire claim, including the primary service, would be associated with a single comprehensive service and all costs reported on the claim would be assigned to that service.*** The comprehensive APC would treat 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 and CPT 69930 Implant Cochlear Device) will be included as a comprehensive APC.*** CMS also proposes to create a new status indicator “J1” to identify HCPCS codes that are paid under a comprehensive APC. For a complete list of status indicators for 2014, click [here](#).

CMS notes that this new policy will allow them to expand the scope of services covered under the OPSS. For example, services such as room and board, durable medical equipment, laboratory services, and therapy services included on the claim with the primary service would be considered adjunctive services which support the primary service under the OPSS. The costs of those adjunctive services would be included in determining the relative weights for the payment of the comprehensive APC, and would not be billed or paid under the separate fee schedules as they are currently. ***This policy will also reduce beneficiary coinsurance for comprehensive APC services, as they will only have one copayment instead of multiple coinsurance for separate services as they do currently. Payment for comprehensive APCs would be made for the largest comprehensive payment associated with the claim based on the listed CPT codes, however, all costs on the claim will be considered in ratesetting for the comprehensive APC.***

#### **Proposed Calculation and Use of Cost-to-Charge Ratios (CCRs) for CT and MRI services**

To address the continuing issue of charge compression and the resulting distortion of relative weights, CMS proposes to calculate OPSS relative payment weights using distinct CCRs for CT scan and MRI, and to continue using the distinct CCR for implantable medical devices which was first used for 2013. 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 2014. Click [here](#) for a list of imaging services, commonly provided by ENTs, which were impacted by this proposed policy change.

#### **OPSS Payment for Hospital Outpatient Visits**

For CY 2014, CMS is proposing to replace the current 5 levels of visit codes describing clinic visits, Type A and Type B emergency department visits, and critical care services with 3 alphanumeric Level II HCPCS codes representing a single level of payment for three types of visits. ***This change, if finalized, would impact all hospital providers who render Type A and B emergency department visits or clinic visits. As such, the Academy intends to comment on this policy proposal in our comments to CMS.***

The Agency notes that while they have previously stated their intent to work with stakeholders to create hospital-specific national guidelines for visit billing, that task has proven challenging and they feel that no single approach could consistently and accurately capture hospitals' relative costs. Therefore, CMS has decided to change course and proposes modification of their longstanding policies related to hospital outpatient clinic and ED visits. They believe a policy that recognizes a single visit level for clinic visits, Type A ED visits, and Type B ED visits for payment under the OPSS is appropriate for several reasons, including:

- The proposal is in line with their goal of using larger payment bundles to maximize hospitals’ incentives to provide care in the most efficient manner.
- They also believe this proposal 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.
- In addition, replacing the 20 HCPCS codes currently recognized for clinic visits and ED visits with three new HCPCS codes will reduce administrative burden and can be easily adopted by hospitals.
- Discontinuing the use of the five levels of HCPCS visit codes for visits 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 and ED 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	<b>GXXC</b>	<b>0634</b>
	99202	0605		
	99203	0606		
	99204	0607		
	99205	0608		
	99211	0604		
	99212	0605		
	99213	0605		
	99214	0606		
	99215	0607		
Type A ED Visit	99281	0609	<b>GXXA</b>	<b>0635</b>
	99282	0613		
	99283	0614		
	99384	0615		
	99285	0616		
Type B ED Visit	G0380	0626	<b>GXXB</b>	<b>0636</b>
	G0381	0627		
	G0382	0628		
	G0833	0629		
	G0834	0630		

### **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. For drugs separately payable in 2014, CMS proposes to **pay for separately payable drugs at the statutory default rate of Average Sales Price (ASP) + 6%**. 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 which is an increase from the \$80/day threshold of 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 OPPTS:**

##### **Supervision of Outpatient Therapeutic Services in CAHs and Small Rural Hospitals**

CMS proposed to end its nonenforcement 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 would 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. *CMS is interested in comments on any impact on access to and quality of care for specific services under this policy.*

##### **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. Application of Therapy Caps to CAHs**

CMS proposes that outpatient therapy services (physical therapy, speech-language pathology, and occupational therapy) furnished by a critical access hospital (CAH) will be subject to therapy caps, the exceptions process, and the manual medical review process in outlined in the [Medicare Physician Fee Schedule 2014 NPRM](#), beginning in 2014 and for subsequent years.

#### **6. Requirements for Billing “Incident To” Services** (see MPFS 2014 Summary linked above)

#### **7. Collecting Data on Services Furnished in Off-Campus Provider-Based Departments** (see MPFS 2014 Summary linked above)

#### **8. 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 proposes 5 new quality measures and removes 2 measures from the OQR program for CY 2016 payment. None of the five 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 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 proposed rule for CY 2014 click:<http://www.gpo.gov/fdsys/pkg/FR-2013-07-19/pdf/2013-16555.pdf>.