AAO-HNS SUMMARY OF CY 2013 HOSPITAL OUTPATIENT AND AMBULATORY SURGICAL CENTER (ASC) PAYMENT SYSTEMS FINAL RULE

On November 1st the Centers for Medicare and 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 HOPPS/ASC final rule by the **December 31, 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 also 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 final rule, CMS implements relative payment weights and payment amounts for services furnished in ASCs, and other rate setting information for the CY 2013 ASC payment system.

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

1. OPPS 2013 Proposed Payment Rates:

CMS' final calculation of the conversion factor for CY 2013 varied slightly from the proposed rule and included an updated estimate of the market basket increase of 2.6%. CMS additionally used an updated multifactor productivity (MFP) adjustment of -.7% with the continued -.1% adjustment as required by the Affordable Care Act (ACA). **As a result, CMS finalized a hospital outpatient conversion factor rate increase of 1.8%, increasing from $70.170 in 2012 to $71.313 in 2013.** CMS has also finalized 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 finalized the use of 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. It also will allow earlier detection of changes in the cost of services and may promote better stability in the payment system. CMS also 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 as well as by size and location of a hospital. Overall, the change does not significantly impact otolaryngology-head and neck surgeons. The use of the geometric mean results in slight positive increases for hospitals with fewer beds (0-99) in both urban and rural areas, but causes slight decreases for hospitals with 200 or more beds in both locations. To see additional details on the impact of this policy see Table 47 of the final rule.

Of note, CMS responded to the Academy, and others', comments urging them to closely monitor the impact of this methodology change and confirmed that they will continue to monitor changes in cost distributions resulting from the use of the geometric mean rather than the median.

Changes to APC Classifications for CY 2013

By statute, the Secretary of HHS is required to review and revise APCs on an annual basis and evaluate whether the services within an APC use comparable resources and are clinically similar. In addition, the median cost of the highest cost item in the APC may not be more than 2 times that of the lowest cost item's median cost. CMS identifies changes to APC assignments for 2013 with a status indicator of "CH". Within the CY 2013 final rule, CMS reassigns a number of ENT services to different APCs, resulting in fluctuations in payment for these services. For example, the sinus endoscopy with balloon dilation procedures (CPT 31295, 31296, and 31297) will remain in APC 0075, but will see a decrease in reimbursement for 2013 due to CMS' decision to add several lower cost procedures to the APC. The 2013 payment rate for APC 0075 is estimated at $2, 026.82 which is down from $2,129.90 in 2012. Members should keep in mind that changes to APC payment do not directly impact physicians, as they are paid for services based on the physician fee schedule's professional component payment rate, the APC payment is provided directly to the hospital and covers their practice expenses in providing medical services. For a complete list of APCs and their associated payment rates, click *here*.

In addition, CMS made several changes to their list of exemptions from the two times rule outlined above. CMS makes exceptions in unusual cases, such as low-volume items and services. Two APCs included on the exception list for 2013 are relevant for the otolaryngology community. Those are APC 0254 Level V ENT procedures and APC 0006 Level I Incision & Drainage. For a complete list of exceptions for CY 2013, access Table 17 in the final rule.

Along with the changes to APC assignments mentioned above, CMS finalized their proposal to create a separate cost center for implantable devices. This means that the payments for these devices which were previously included in the applicable procedure's APC payment will be made separately under a new APC. While this policy change appears to cause the payment rates for many procedures to go down, physicians and hospitals should be aware that they will now be able to bill for two APCs (the procedure APC and the device APC), where applicable, and that overall payment may not be reduced.

Device Dependent APCs

Within the final rule, CMS also finalized their proposed payment for a cochlear implant device (CPT 69930) of $30,326.87. This represents an increase of 5.8% from CY 2012. Despite comments on the proposed rule that this payment rate does not capture the actual cost of the procedure and device due to potential coding errors by hospitals between this code and a less expensive osseointegrated auditory device implant procedures, CMS is finalizing the payment rate for CY 2013 and notes they conducted a review of claims and did not find any evidence of such coding errors.

APC Assignments for New 2013 CPT Codes

After the proposed rule was issued, the AMA CPT Editorial Panel created new CPT codes which will be effective January 1, 2013. New CPT codes relevant to otolaryngology-head and neck surgeons include two new pediatric polysomnography codes (CPT 95782 and 95783) and several new allergy codes, including two ingestion challenge codes (95076 and 95079) and two percutaneous and intracutaneous allergy testing codes (95017 and 95018).

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 2013, CMS finalized their proposal 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 OPPS for drugs and biologicals.

Payment for Packaged Drugs and Biologicals:

In the final rule CMS finalizes the 2013 packaging threshold for drugs and biologicals 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 plus the drug/biological used during the procedure. This threshold is an increase from the $75/day threshold used in 2012.

4. OPPS Payment for Hospital Outpatient Visits

Hospital Outpatient Visit Policies:

Currently, hospitals report HCPCS visit codes to describe three types of OPPS services: clinic visits, emergency department visits, and critical care services, including trauma team activation. For CY 2013, CMS will continue to recognize these CPT and HCPCS codes describing clinic visits, Type A and Type B emergency department visits, and critical care services. A complete list of these codes can be found in Table 38 of the final rule.

For 2013, CMS will 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 edits that package 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.

In the Academy's August 2012 comment letter to CMS, we recommended that CMS cap the amount of time a beneficiary can receive observation services as an outpatient to provide clarity to requirements and urged CMS to increase transparency of patient status for both patients and physicians. The Academy also recommended that CMS automatically define anyone who had received care in the facility setting for more than 48 hours as an inpatient. In response, CMS notes they received over 350 comments on this policy area; however, they did not implement any immediate changes in regarding these policies and stated they will take all public comments into consideration as they consider future action. CMS did, however, finalize their proposal to implement a 3 year Medicare Part A to Part B rebilling demonstration, beginning with 2012, which will allow hospitals to rebill a Part A short stay claim that is denied because the inpatient admission is deemed not reasonable and necessary.

Transitional Care Management:

Within the proposed rule, CMS proposed the creation of a HCPCS G-code to describe the work involved with care management and coordination furnished by a treating physician during a hospital stay, SNF stay, or Community Mental Health Center partial hospitalization to transition the beneficiary back to their primary care provider in the community. However in the final rule, as was the case in the Medicare Physician Fee Schedule final rule, CMS states that in lieu of

their proposed G code, they will adopt two new CPT codes developed by an AMA Chronic Care Coordination workgroup (C3W). The new codes are CPT 99495 and 99496.

Like the proposed G code, CMS states that the new codes ARE NOT billable by a physician or non-physician billing for a procedure with a 10 or 90 day global period because they consider such management "included in the post-operative portions of the global period." However, CMS does clarify that the use of these codes is NOT restricted to primary care physicians and specialists who furnish the requisite services in the code descriptions may also bill the new TCM codes, so some otolaryngology-head and neck surgeons may be able to use these codes.

5. Clarification of Supervision Requirements in the OPPS:

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). Of note, the list of "sometimes therapy" codes include negative wound pressure therapy codes as well as several debridement codes which may be utilized by otolaryngology-head and neck surgeons.

Supervision of Outpatient Therapeutic Services in CAHs and Small Rural Hospitals

For CY 2013, CMS finalized another 1 year extension of its policy of "non-enforcement" of the direct supervision requirement for outpatient therapeutic services. This exception only applies to CAHs and small rural hospitals through 2013. The Agency reiterates that this will be the last year of this extended policy. CMS notes that the APC Panel has considered several requests for changes to the supervision level for certain services, including observation services, skin/wound care, and administration of certain drugs and agents, and the Agency will issue final decisions before January 1, 2013 on its website.

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**. As originally proposed by CMS, Hospitals that are not currently participating in the Hospital OQR Program will have until July 31 of the year prior to the affected annual payment update to submit a participation form. Program measures can be accessed at: www.QualityNet.org.
- ***Quality Reporting Measures:*** CMS did not add any new measures for CY 2013 quality reporting. The Academy continues to express concern to CMS that there are not sufficient measures for specialists, such as otolaryngology, to meaningfully report on, and therefore, they are left to report on generic measures such as tracking clinical results between visits.
- ***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 has confirmed that it will continue, in 2013, the Electronic Reporting Pilot that was finalized for 2012. Regulations will 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 can continue to report clinical quality measure results by attestation under the Medicare EHR Incentive Program. In its final rule, CMS stated that they are working toward allowing eCQM data submitted via certified EHR technology by eligible professionals (EPs), eligible hospitals, and CAHs, to apply to other CMS quality reporting programs. CMS is also working towards aligning several of its quality reporting programs in an effort to relieve administrative burden.

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

1. **ASC 2013 Final Payment Rates:**

In its final rule CMS utilized the updated Consumer Price Index for All Urban Consumers (CPI-U) of 1.4% minus an updated MFP adjustment, projected to be .8%, and as a result will implement a .6% increase to the ASC conversion factor. These changes result in a CY 2013 conversion factor for ASCs of $42.917 compared to the 2012 CF of $42.627. The table below reflects the major categories of procedures in the ASC setting, the amount paid to each category 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 Integumentary and Respiratory, but see slight increases for Auditory services.

Surgical Specialty Group	Estimated 2012 ACS Payments (in Millions)	Estimated 2013 Percent Change
Total	$3,480	1%
Eye and ocular adnexa	$1,453	0%
Digestive system	$719	2%
Nervous system	$471	3%
Musculoskeletal system	$433	-2%
Genitourinary system	$160	0%
Integumentary system	$131	-3%
Respiratory system	$45	-3%
Cardiovascular system	$31	-3%
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. **In the CY 2013 final rule CMS has finalized, 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 confirms that CMS will pay for these procedures at the **lesser of** the 2013 MPFS non-facility Practice Expense (PE) relative value unit (RVU) amount, or the proposed 2013 ASC payment amount.

Payment for Device-Intensive Procedures in the ASC Setting:

CMS finalized 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 also updated 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 rules. **Notably, CPT 69930, implantation of cochlear devices is one of the services for for which this policy will apply in CY 2013**. The Agency has also published 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) which includes: **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). CMS reiterated its intention to align measures across the ASCQR and the OQR as much as possible to relieve administrative burden. The measures can be found at: www.Qualitynet.org.
- ***Effective Date:*** **CMS finalized OCTOBER 2012 as the date by which ASCs were required to begin reporting 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 claim**s.**

- ***Quality Reporting Measures:*** CMS did not add any new measures for CY 2013 quality reporting. The Academy continues to express concern to CMS that there are not sufficient measures for specialists, such as otolaryngology, to meaningfully report on, and therefore, they are left to report on generic measures such as hospital transfer/admission.
- ***Payment reductions:*** In this rule, CMS finalized implementation of the ASCQR program which will include the **2% payment reduction for ASCs who fail to properly report their quality data.**

Additional Resources: To access the full final rule for CY 2013 click: http://www.gpo.gov/fdsys/pkg/FR-2012-11-15/pdf/2012-26902.pdf. 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.*