



# VCU Medical Center

## Office of Health Innovation

### Final Rule with Comment Period – Medicare OPPS and ASC for CY 2014

**Description:** This final rule with comment period revises the Medicare hospital outpatient prospective payment system (OPPS) and the Medicare ambulatory surgical center (ASC) payment system for CY 2014 to implement applicable

**Citation:** 78 FR 74825 statutory requirements and changes arising from our continuing experience  
**Publish Date:** December 10, 2013 with these systems. In this final rule with comment period, CMS describes  
**Comments Due:** January 27, 2014 the changes to the amounts and factors used to determine the payment  
**Effective Date:** January 1, 2014 rates for Medicare services paid under the OPPS and those paid under the ASC payment system. In addition, this final rule with comment period updates and refines the requirements for the Hospital Outpatient Quality Reporting (OQR) Program, the ASC Quality Reporting (ASCQR) Program, and the Hospital Value-Based Purchasing (VBP) Program.

### Major Provisions

#### Changes to CY 2014 OPPS

#### Payment Updates

- The final rule includes a productivity reduction required by PPACA of **0.5 percent** and an additional **0.3 percent** reduction to the CY 2014 market basket update of 2.5 percent.
  - This results in a net market basket update of **1.7 percent** for those hospitals that publicly report data on 24 quality measures.
- The 2014 update for hospitals that do not meet quality reporting requirements will be negative **0.3 percent**.
- The CY 2014 OPPS conversion factor for hospitals meeting quality data reporting requirements is **\$72.762**.
  - CMS calculated this amount by increasing the CY 2013 conversion factor by the new net hospital MB update ( $\$71.313 \times 1.7\%$ )
- CMS per-case payment changes:

<b>All Hospitals</b>	<b>1.9%</b>
Urban Hospitals	2.0%
Large Urban	2.2%
Other Urban	1.7%
Rural	1.1%
Sole Community	1.6%
Other Rural	0.8%

## Coding and Payment for Hospital Outpatient Visit Services

- CMS finalizes its proposal to collapse the current 10 codes for hospital outpatient clinic visits – including CPT codes 99201-99205 for new patient visits and CPT codes 99211-99215 for established patient visits – and replace them with one new Healthcare Common Procedure Coding System (HCPCS) code, G0463, representing a single level of payment for all hospital outpatient clinic visits.
- The current clinic visit codes, including the distinctions between new and established patient visits, will no longer be recognized after 2013.
- CMS does not finalize its proposal to similarly collapse the 10 Type A and Type B ED visit codes, and will maintain the existing five codes for each of these types of ED visit.

## Establishing Comprehensive Device-Dependent APCs

- CMS finalizes the creation of 29 new comprehensive APCs to replace the 29 existing device-dependent APCs, but delays their implementation until CY 2015.
- The comprehensive APCs will package into the primary procedure all of the following categories of services that CMS considers to be integral, ancillary, supportive, dependent and adjunctive to the primary services:
  - Otherwise packaged services and supplies;
  - Adjunctive services;
  - DMEPOS;
  - Outpatient department services reported by therapy codes; and
  - Hospital-administered drugs.
- Payment for comprehensive APCs:
  - When the comprehensive APCs are implemented in CY 2015, the claims processing system will make a single payment for the device-dependent comprehensive service whenever a HCPCS code for one of the primary procedures assigned to status indicator “J1” appears on the claim.
  - All other adjunctive services on the claim – except mammography, ambulance, brachytherapy sources and drugs, biological, and devices receiving pass-through payment – will be conditionally packaged when a comprehensive service is identified on a claim.

## Composite APCs

- For CY 2014, CMS will replace the current EAM composite APCs 8002 (Level I EAM Composite) and 8003 (Level II EAM Composite) with a single assessment and management composite APC (APC 8009).
- The 2014 payment rate for APC 8009 is **\$1,199** compared to the 2013 payment rates of \$440.07 for APC 8002 and \$798.47 APC 8003.

## New Categories of Packaged Services

- For CY 2014, CMS finalizes its proposals to expand packaging to five additional categories of items and services:
  - Drugs, biologicals, and radiopharmaceuticals that function as supplies when used in a diagnostic test or procedure;
  - Drugs and biologicals that function as supplies when used in a surgical procedure;
  - Clinical diagnostic laboratory tests;
  - Procedures described by add-on codes; and
  - Device removal procedures.

- CMS did not finalize expanding packaging to:
  - Ancillary services (status indicator “X”); and
  - Diagnostic tests on the bypass list.

### Packaging of Lab Tests

- CMS finalized its proposal to package lab tests when they are integral, ancillary, supportive, dependent or adjunctive to a primary service or services.
- Lab tests will not be packaged when:
  - The lab test is the only service provided to beneficiaries on that date of service
  - The test is conducted 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.

### Refinement of the APC Relative Weight Calculation

- Beginning in CY 2014, CMS will calculate the OPSS relative payment weights using three additional CCRs, one each for MRIs, CT scans and cardiac catheterization and will continue to use a distinct CCR for implantable medical devices.

### Outlier Payments

- For CY 2014, CMS sets the projected target for outlier payments at 1 percent of total OPSS payments – the same as in CY 2013.
- CMS again establishes separate thresholds for community mental health centers (CMHCs) and hospitals.
  - Therefore, **0.16 percent** of outlier payments will be allocated to CMHCs for partial hospitalization program (PHP) services.
- The rule continues to include both a fixed-dollar outlier threshold and a percentage threshold, but in CY 2014 CMS increases the fixed-dollar threshold to **\$2,900** (from \$2,025 in CY 2013).
- When the cost of a hospital outpatient service exceeds these applicable thresholds, Medicare makes an outlier payment that is 50 percent of the amount by which the cost of furnishing the service exceeds 1.75 times the APC payment rate.

### Supervision of Hospital Outpatient Therapeutic Services

- On Jan. 1, 2014, CMS will end its prohibition on Medicare contractors enforcing the direct supervision policy for outpatient therapeutic services furnished in CAHs and in small rural hospitals having 100 or fewer beds.
- CMS encourages hospitals to use the Advisory Panel process for potential changes to minimum supervision levels.
- CMS clarifies that, once the supervising physician or appropriate NPP determines and documents that the patient is stable, general supervision may be furnished throughout the duration of the observation service without additional initiation periods of direct supervision during the service.

### Hospital Outpatient Quality Reporting (OQR) Program

- CMS finalizes the removal of two measures and adds four of the five new measures it proposed for the OQR program in CY 2016.
- Measure removal:

- OP-19: Transition Record with Specified Elements Received by Discharged Emergency Department (ED) Patients
- OP-24: Cardiac Rehabilitation Patient Referral From an Outpatient Setting
- New measures for CY 2016
  - OP-27: Influenza Vaccination Coverage Among Healthcare Personnel
  - OP-29: Endoscopy/Poly Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients
  - OP-30: Endoscopy/Poly Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps; Avoidance of Inappropriate Use
  - OP-31: Cataract Surgery Outcome Measure

### **Hospital Value-Based Purchasing Program**

- CMS finalizes three HAI measures for the FY 2016 VBP program:
  - Central-line associated blood stream infection (CLABSI);
  - Catheter-associated urinary tract infection (CAUTI); and
  - Surgical site infection (SSI).
- For the three HAI measures, CMS finalizes a baseline period of CY 2012 (Jan. 1, 2012 – Dec. 31, 2012) and a performance period of CY 2014 (Jan. 1, 2014 – Dec. 31, 2014).
- CMS included in the final rule an additional Independent review process for hospitals dissatisfied with the outcome of their appeal.

### **Requirements for Billing “Incident To” Services**

- CMS finalizes its proposal to require as a condition of payment that an individual who provides services and supplies “incident to” a physician’s professional services must meet any applicable state requirements, including licensure, and that those services and supplies be provided in accordance with state law.

### **Changes for the CY 2014 ASC Payment System**

#### **Updates and Changes to ASC Payment Policy**

- CMS applies a **1.0009** ASC wage index budget neutrality adjustment in calculating the 2014 ASC conversion factor.
- CMS will apply to the ASC conversion factor a net update of **1.2 percent**.
- This update, together with the wage adjustment for budget neutrality, results in a final CY 2014 ASC conversion factor of **\$43.471**.

### **ASC Quality Reporting (ASCQR) Program**

- CMS finalizes three of the four measures it proposed to add to the ASCQR program for CY 2016 payment determination:
  - ASC-9: Endoscopy/Poly Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients
  - ASC-10: Endoscopy/Poly Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps—Avoidance of Inappropriate Use
  - ASC-11: Cataracts—Improvement in Patients Visual Function within 90 Days Following Cataract Surgery

