KEY TAKEAWAYS FROM 2020 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM FINAL RULE

On November 1, 2019, the Centers for Medicare & Medicaid Services ("CMS") released its final rule for the Calendar Year ("CY") 2020 Hospital Outpatient Prospective Payment System ("Final Rule"). Among many other changes, CMS finalized three key payment policy updates impacting hospital outpatient departments, including: (1) reducing payments for clinic visits at off-campus provider-based departments ("PBDs"); (2) revising the supervision standard for hospital outpatient therapeutic services from direct supervision to general supervision; and (3) requiring prior authorizations for certain hospital outpatient department services. Notably, CMS did not finalize its hospital price transparency provisions that were included in the CY 2020 OPPS Proposed Rule ("Proposed Rule"). Instead, CMS stated it would summarize and respond to public comments on the proposed transparency policies in a forthcoming final rule. The Final Rule also announced that CMS will continue its policy of paying hospitals 22.5 percent less than the average sales price for certain drugs purchased through the 340B Program (a more detailed analysis on this topic will be provided in a forthcoming article).

REDUCTION IN PAYMENTS FOR CLINIC VISITS AT OFF-CAMPUS PROVIDER-BASED HOSPITAL DEPARTMENTS

CMS finalized its proposal to reduce payment for evaluation and management ("E/M") services (as described by HCPCS code G0463) at *all* off-campus PBDs. The Final Rule completes the two-year phase-in of the reduction in payment for E/M services furnished in excepted off-campus provider-based departments. Therefore, if a hospital bills for an E/M service at an excepted (grandfathered) off-campus PBD, as indicated by billing with the PO modifier, it will be paid at 40 percent of the OPPS rate in 2020 (a 60 percent payment reduction).

CMS is making this change in a non-budget neutral manner. The agency estimates this change will result in reduced payments (between the Medicare Program and beneficiary copayments) of $800 million for CY 2020.

CMS moved forward with the cuts while acknowledging the D.C. District Court's September 17th determination that this site-neutral payment policy exceeded CMS's statutory authority to adjust payments under the OPPS as discussed in our previous article. CMS stated they are working to ensure affected 2019 claims for clinic visits are paid consistent with the court's order. CMS further stated it does not believe it is appropriate at this time to make a change to the second year of the two-year phase-in of the clinic visit policy and it is still evaluating the rulings and considering whether to appeal from the final judgment.

GENERAL SUPERVISION STANDARD FOR OUTPATIENT THERAPEUTIC SERVICES IN HOSPITALS AND CRITICAL ACCESS HOSPITALS

In a move widely supported by the industry, CMS finalized its proposal to change the required level of physician/practitioner supervision from direct to general for all outpatient therapeutic services provided in PPS hospitals and critical access hospitals. As defined under 42 CFR § 410.32(b)(3)(i), "general supervision" means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. The Final Rule thus ends the previous two-tiered system outlined in our previous article on the Proposed Rule by uniformly requiring general supervision for all outpatient therapeutic services furnished incident to a physician's service in PPS hospitals and critical access hospitals. Hospitals may still choose to require higher levels of supervision for certain services as it deems appropriate, and CMS will retain the ability to consider a change to the supervision level of an individual hospital outpatient therapeutic service that is more intensive than general supervision through notice and comment rulemaking.

PRIOR AUTHORIZATION PROCESS FOR CERTAIN HOSPITAL OUTPATIENT DEPARTMENT SERVICES

To address what CMS has identified as unnecessary increases in the volume of covered outpatient department services that may be considered cosmetic surgical procedures masquerading as covered therapeutic services, CMS proposed to implement prior authorization as a method for controlling improper payments and decreasing the volume of potentially improperly billed services. In our article on the Proposed Rule, we outlined the agency's proposed new prior authorization process for the following five specific outpatient therapeutic services: (1) blepharoplasty; (2) botulinum toxin injections; (3) panniculectomy; (4) rhinoplasty; and (5) vein ablation ("Service Categories").

CMS finalized its proposal to implement a new regulation at § 419.82 requiring that, as a condition of Medicare payment, a provider must

submit a prior authorization request for a hospital outpatient department service requiring prior authorization to CMS effective July 1, 2020. In the Final Rule, CMS finalized this required prior authorization process for the Service Categories as proposed requiring the prior authorization request include all documentation necessary to show the service meets applicable Medicare coverage, coding and payment rules and be submitted before the service is furnished to the beneficiary and before the claim is submitted. If the request meets the applicable Medicare coverage, coding and payment rules, CMS or its contractor would issue a provisional affirmation to the requesting provider. If the request does not meet the applicable Medicare coverage, coding and payment rules, CMS or its contractor would issue a non-affirmation decision to the requesting provider within 10 business days. If a provider receives a non-affirmation decision, the provider may resubmit a prior authorization request with any applicable additional relevant documentation. Additionally, an expedited review process is available when requested by a provider and CMS or its contractor determines that a delay could seriously jeopardize the beneficiary's life, health or ability to regain maximum function.

Claims submitted for services that require prior authorization that have not received a provisional affirmation of coverage from CMS or its contractors would be denied, unless the provider is exempt from the prior authorization process. In its Proposed Rule, CMS stated it may elect to exempt a provider upon a provider's demonstration of compliance with Medicare coverage, coding and payment rules by achieving a provisional affirmation threshold of at least 90 percent during a semiannual assessment. CMS finalized this proposal, with minor modification, to clearly set forth notice of an exemption/withdrawal of an exemption. Accordingly, CMS revised § 419.83(c) to state that an exemption will remain in effect until CMS elects to withdraw an exemption. Further, CMS added a new provision to paragraph (c)(2) that will account for the notice of exemption or withdrawal of an exemption being delivered at least 60 calendar days prior to the implementation date. Finally, CMS finalized its proposal to reserve the right to suspend the outpatient department services prior authorization process requirements generally or for a particular service(s) at any time by issuing notification on CMS's web page.

A list of the specific CPT codes for outpatient services that require prior authorization are published in the Final Rule. It is important to note that the prior authorization requirements would only apply to hospitals paid under the OPPS and not other provider/supplier types, such as freestanding physician offices or ASCs.

PRICE TRANSPARENCY INITIATIVE SEPARATED AND DELAYED

Finally, in the Proposed Rule, CMS proposed to add new regulations on a price transparency initiative pursuant to § 2718(e) of the Public Health Service Act, as added by ACA section 1001, and President Trump's executive order on price and quality transparency. The proposed initiative, a first of its kind, would require hospitals to publish payer-specific negotiated rates for 300 heavily consumed services, including 70 defined by CMS, in a searchable and consumer-friendly manner. However, CMS did not finalize this proposed policy in the Final Rule; rather, CMS indicated it will issue a separate final rule regarding this proposal. Stay tuned for additional health law alerts addressing this initiative.

PRACTICAL TAKEAWAYS

- Despite the policy being vacated by a federal judge in September, CMS finalized its payment reductions for E/M clinic visits at excepted (grandfathered) off-campus PBDs. In 2020, such services will be paid at 40 percent of the OPPS rate. Hospitals should analyze the impact of this reduction in payments and continue to preserve appeal rights related to those services for CY 2020.
- CMS finalized its proposal that outpatient therapeutic services at all PPS hospitals and CAHs will require *general supervision*, rather than *direct*, to match the policy previously applied at CAHs and small rural hospitals. Hospitals should assess patient care needs when assessing the level of supervision that it will require.
- CMS finalized its proposal for required prior authorization for the following services: (1) blepharoplasty; (2) botulinum toxin injections; (3) panniculectomy; (4) rhinoplasty; and (5) vein ablation, which take effect July 1, 2020.
- Hospitals should review the CMS price transparency proposals and stay tuned for continued developments on this subject.
- CMS will continue its policy of paying hospitals 22.5 percent less than the average sales price for certain drugs purchased through the 340B Program for 2020.

If you have questions or would like additional information about this topic, please contact:

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