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HEALTH LAW NEWS

DECEMBER 09, 2013

CMS PUBLISHES 2014 OUTPATIENT PROSPECTIVE PAYMENT SYSTEM AND AMBULATORY SURGICAL CENTER FINAL RULE

On November 27, 2013, the Centers for Medicare & Medicaid Services ("CMS") issued the Outpatient Prospective Payment System ("OPPS") and Ambulatory Surgical Center ("ASC") Final Rule ("Final Rule"). In this Final Rule, CMS made some significant changes, including implementing a policy to combine outpatient clinic evaluation and management visit codes into one APC and allowing the non-enforcement of the supervision requirement for therapeutic services for certain hospitals to expire. CMS also amended the conditions of payment for outpatient therapeutic incident to services. A summary of these and other program changes is discussed below.

SINGLE PAYMENT LEVEL FOR OUTPATIENT CLINIC VISITS

CMS finalized a policy that will eliminate the existing five levels of hospital outpatient clinic visit codes for both new and established patients and replace them with a new HCPCS code (G0463) that will represent a single level of payment for all hospital outpatient clinic visits. The new HCPCS code will apply to all outpatient clinic visits (except emergency room visits) paid under the OPPS regardless of the level of effort and regardless of whether the patient is a new or established patient. Effective January 1, 2014, CMS will no longer recognize CPT codes 99201 through 99205 (new patient clinic visits) and 99211 through 99215 (established patient clinic visits) under the OPPS.

CMS stated that this new system will reduce the hospital's administrative burden and will be easy to adopt and comply with. For example, this new policy will eliminate the need for hospitals to develop and apply their own internal guidelines to differentiate between levels of clinic visits. It is also in line with CMS's goal of using large payment bundles to incentivize hospitals to provide care in more efficient manners. Notably, CMS did not finalize its proposal to replace the current five levels of codes for emergency department visits but is considering options to improve codes for these services in future rulemaking.

CMS dismissed hospitals' concerns regarding this new policy, including the concern that it will not adequately reimburse providers that serve patients with a more complex case-mix and that hospitals will lose the ability to track patient acuity for clinic visits.

CMS did not make this same change for services paid under the physician fee schedule, so physician services will continue to be coded and paid based on the five evaluation and management levels for new and established patients. As a result, there will continue to be a payment difference for facility evaluation and management services billed and paid as hospital outpatient services (although hospitals should assess the impact of this change in payment). If providers retain provider-based status and bill the facility services on a hospital claim form, hospitals should continue to comply with Medicare's provider-based rules.

SUPERVISION OF HOSPITAL OUTPATIENT THERAPEUTIC SERVICES

In the 2009 OPPS/APC Final Rule, CMS clarified that direct supervision was required for hospital outpatient therapeutic services in hospitals and provider-based departments. CMS later clarified that this requirement applied to both hospitals and critical access hospitals ("CAHs"). However, in response to concerns that small rural hospitals would have difficulty meeting these requirements, CMS instructed contractors not to enforce the supervision requirement for therapeutic services provided to outpatients in CAHs and small rural hospitals having 100 or fewer beds. This exception was set to expire at the end of 2013.

In the Final Rule, CMS stated that it would allow the non-enforcement of the supervision requirement for therapeutic services for CAHs and small rural hospitals to expire on December 31, 2013. Therefore, beginning January 1, 2014, CAHs and small rural hospitals will be required to abide by the supervision requirements for therapeutic services.

OUTPATIENT THERAPEUTIC "INCIDENT TO" SERVICES

The Final Rule amends the Medicare conditions of payment for therapeutic outpatient hospital or CAH services and supplies furnished "incident to" a physician's or non-physician practitioner's service to require individuals furnishing such services be qualified to furnish those services under the scope of practice laws of the state in which the services are provided. Previously, CMS generally deferred to hospitals to ensure that practitioners were following state scope of practice and other rules related to delivery of health care services.

This change makes clear that Medicare contractors could deny or recoup payment for outpatient therapeutic services performed "incident

to" a physician's or non-physician practitioner's service if such services are not furnished in accordance with state law. CMS did state that this does not impose any new requirements on providers since they are already required to comply with state law.

EHR INCENTIVE PAYMENTS FOR ELIGIBLE PROFESSIONALS REASSIGNING TO METHOD II CAHS

In the Final Rule, CMS finalized regulations to provide a special method for making hospital-based determinations for 2014 in cases of eligible professionals ("EPs") who reassign their benefits to CAHs billing under Method II. Method II billing allows CAHs to receive a cost-based payment for facility costs of providing outpatient services plus 115% of the Medicare physician fee schedule amount for professional services reassigned to the CAH.

Previously, CMS was unable to make EHR payments to these EPs for their Method II CAH claims or to take those claims into consideration in making hospital-based determinations because of systems limitations. This change will allow CMS to begin making payments based on Method II CAH claims for payment year 2013, one year before it would have been able to under the prior regulations.

HOSPITAL OUTPATIENT QUALITY REPORTING PROGRAM AND ASC QUALITY REPORTING PROGRAM

CMS added four new quality measures to the Hospital Outpatient Quality Reporting ("HOQR") program for CY 2016, including one health care-associated infection (Influenza Vaccination Coverage among Healthcare Personnel) and three chart-abstracted measures (Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients; Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps - Avoidance of Inappropriate Use; and Cataracts - Improvement in Patient's Visual Function Within 90 days). Future quality measures under consideration by CMS include measures addressing clinical quality of care, care coordination, patient safety, patient and caregiver experience of care, population/community health and efficiency. CMS believes this approach will further align the HOQR program with other quality reporting systems in place in similar settings.

For CY 2016 payment determination, CMS adopted the same three chart-abstracted measures finalized in the HOQR Program for inclusion in the ASC Quality Reporting ("ASCQR") Program. Finalizing these new measures in the HOQR and ASCQR programs further aligns the measures across outpatient hospital and ambulatory settings, which furnish many similar services to beneficiaries.

HOSPITAL VALUE-BASED PURCHASING PROGRAM

CMS finalized the performance and baseline periods for three measures applicable to the FY 2016 Hospital Value-Based Purchasing Program: central line-associated bloodstream infection, catheter-associated urinary tract infection and surgical site infection. CMS established the final baseline period as January 1, 2012 through December 31, 2012 and the final performance period as January 1, 2014 through December 31, 2014. Although these same measures are also part of the Hospital Acquired Conditions Reduction Program, meaning hospitals could be penalized under both programs, CMS stated its strong belief that hospitals should continue to be encouraged to minimize infection events that present significant health risks to patients.

The Final Rule also establishes an independent CMS review procedure that will be available to hospitals as an additional appeal process beyond the existing review and appeal processes. This independent CMS review process will only be available to hospitals dissatisfied with the existing appeal process and would require CMS to provide hospitals with a determination within 90 calendar days following receipt of hospital's request for independent CMS review.

CHANGES TO CONDITIONS FOR COVERAGE FOR ORGAN PROCUREMENT ORGANIZATIONS

CMS modified the recertification requirement for Organ Procurement Organizations ("OPO") and now only requires two of the three outcome measures to be satisfied. CMS recognized that the original requirement to meet all three outcome measures was unnecessarily stringent and that many OPOs were performing satisfactorily when only two of the three outcome measures were met. The intent of CMS was to allow OPOs to continue developing relationships with hospitals and health care systems without unnecessary disruptions caused by the recertification process.

PAYMENT RATES

The OPPS conversion factor increased from $71.313 in CY 2013 to $72.672 for CY 2014. This increase represents a fee schedule increase factor of 1.7% (a 2.5% market basket percentage increase, minus the multifactor productivity adjustment of 0.5% and a 0.3% adjustment required by the Affordable Care Act) as well as various budget neutrality adjustments. Total payments under the OPPS are estimated to be $50.4 billion (including beneficiary cost-sharing), which is an increase of approximately 9.5% over CY 2013 payments.

The ASC conversion factor increased from $42.917 in CY 2013 to $43.471 for CY 2014. This increase represents a multifactor productivity adjusted CPI-U update of 1.2% (a 1.7% CPI-U update minus a multifactor productivity adjustment of 0.5%) and a 1.0009 wage index budget neutrality adjustment. Total payments to ASCs are estimated to be $3.992 billion, which is an increase of approximately 5.3% over CY 2013 payments.

The Final Rule will appear in the December 10, 2013 issuance of the Federal Register and certain sections of the Final Rule, which are listed in the Supplementary Information Section, are open for comment until January 27, 2014. A display copy of the Final Rule is available here.

PRACTICAL CONSIDERATIONS

CAHs and small rural hospitals must comply with the direct supervision requirement for outpatient therapeutic services by January 1, 2014. Since supervision is a condition of payment, it is important for these providers to implement appropriate policies and ensure proper supervision.

For hospitals with outpatient clinics, including outpatient provider-based departments, the change to a single-level outpatient visit code will affect facility payments. Hospitals should review financial data in order to be prepared for the change, which could be either positive or negative depending on utilization and prior internal coding assignment of facility resources.

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

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