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CMS Issues CY 2016 Final Rule for Hospital Outpatient and Ambulatory Surgical Center Policy and Payment Changes [Ober|Kaler]

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On October 30, 2015, CMS issued its final policy changes, quality provisions and payment rates for the Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System for calendar year (CY) 2016, finalizing most of its proposals, subject to certain public comments.

As indicated by CMS, the final rule is part of a broader effort to "create a health care system that results in better care, smarter spending, and healthier people." The final rule will be available on November 13, 2015. Below are some of the highlights of the final rule.

Two-Midnight Rule

CMS finalized changes to the Two-Midnight Rule, making certain stays of less than two midnights payable under Medicare Part A on a case-by-case basis, based on the admitting physician's medical judgment. The medical record must support an inpatient admission, subject to medical review. CMS reiterated the expectation that inpatient admission is rarely necessary for minor surgical procedures or other treatments expected to keep a beneficiary in the hospital for a period of time that is only a few hours and does not span at least overnight. Although Quality Improvement Organizations (QIOs), not MACs or Recovery Auditors (who are financially incentivized), will perform initial reviews of two-midnight determinations, QIOs will refer providers to Recover Auditors for additional review based on high rates of claims denials or failure to improve after QIO assistance.

OPPS and ASC Payment Updates

CMS finalized OPPS payment rates to account for the projected hospital market basket increase, inflation in the OPPS payment rates resulting from excess packaged payment for laboratory tests paid outside of the OPPS, a multi-factor productivity percentage and other required adjustments. The result is a final rate update of -0.3 percent. Notably, after all of the other policy changes finalized under the OPPS, CMS predicts a -0.4 percent change in spending for hospitals paid under the OPPS in CY 2016. Also, beneficiary co-insurance for OPPS services is projected to decrease from 19.9 percent to 19.3 percent in CY 2016.

Meanwhile, under the ASC Payment System, the mandatory CPI-U update for CY 2016 is 0.8 percent. When modified by the multi-factor productivity adjustment of 0.5 percent, the result is a multi-factor productivity-adjusted CPI-U update factor of 0.3 percent.

Laboratory Services

CMS finalized updates to reduce the CY 2016 conversion factor to account for inflation in OPPS payments resulting from excess packaged payment under the OPPS. Specifically, to prevent excess payment from carrying through from CY 2014 to CY 2016, CMS is reducing the conversion factor by 2.0 percent. Additionally, CMS created a new conditional packaging status indicator for laboratory tests so that hospitals can more easily receive separate payment for lab tests that are provided without other OPPS services.

Chronic Care Management (CCM) Services

In response to confusion among hospitals on their role in furnishing CCM services, CMS clarified and defined certain scope of service elements for the hospital outpatient setting, which are analogous to those elements finalized as requirements to bill for CCM services in the 2015 Physician Fee Schedule. CMS also addressed technical questions to the Electronic Health Record (EHR) criteria.

Ambulatory Payment Classifications (APCs)

CMS had proposed to reorganize and consolidate the APCs to result in fewer APCs for nine clinical APC families. For CY 2016, CMS finalized the restructuring of nine clinical families, with certain modifications as a result of public comments.

Comprehensive Ambulatory Payment Classifications (C-APCs)

CMS is adding nine new C-APCs for CY 2016, including surgical C-APCs and a new C-APC for Comprehensive Observation Services (COS). With regard to the new C-APC for COS, CMS is finalizing a proposal to provide payment for all services furnished during a non-surgical outpatient encounter where the patient receives 8 hours or more of observation with a high level outpatient hospital visit. CMS will exclude all surgical procedures from being bundled into the COS C-APC, regardless of service date. All emergency department visits, whether high level or not, will be included in criteria for qualifying the COS C-APC.

CMS also finalized a proposal to separately pay for certain adjunctive services related to a C-APC for Stereotactic Radiosurgery as a data collection strategy to improve payment. Meanwhile, in response to comments, CMS is not finalizing a related proposal to require hospitals to report C-APC adjunctive services for CY 2016, except for cranial single session Stereotactic Radiosurgery.

Packaged Services

CMS is finalizing its proposal to package some additional ancillary services, in particular some minor procedures and pathology services (excluding cochlear implant and auditory implant programming services). Several drugs that function as supplies in surgical procedures also will be packaged.

Relatedly, for the list of ASC covered ancillary services, CMS will now exclude codes for services currently on the covered ancillary services list that are not provided ancillary and integral to a covered ASC surgical procedure. Specifically, the Stereotactic Radiosurgery treatment services CPT codes will be removed from the ASC covered ancillary services list.

Device Pass-Through Process Changes for the OPPS

CMS, which currently accepts and reviews device pass-through application on a quarterly basis, is adding an additional evaluation step through annual rulemaking. CMS also is adding a "newness" criterion for device pass-through applications, requiring the application to be submitted within three years of FDA clearance (or the date of market availability where there is a documented, verifiable delay in market availability after FDA clearance).

Skin Substitutes

CMS is finalizing a policy to calculate the "high/low cost group" threshold (a methodology for classifying skin substitutes to improve resource homogeneity among APC assignments for skin substitutes). The calculation will be based on either the mean unit cost or the per patient, per day cost. Where a product exceeds the threshold under either methodology, it will be assigned to the "high cost" group.

Pathogen-Reduced Blood Products

The Healthcare Common Procedure Coding System (HCPCS) Workgroup is creating three new codes for pathogen-reduced blood products, and interim payment amounts in the OPPS will be based on crosswalks to existing blood product codes until claims data accumulates for the new products.

Partial Hospitalization Program (PHP) Update

The rule updates Medicare payment rates setting process for the PHP services in outpatient departments and community mental health centers, in order to trim aberrant costs under two new methodologies. CMS also corrected the geometric mean per diem costs for hospital-based Levels 1 and 2, which had been inverted, by applying an equitable adjustment to calculated final hospital-based PHP per diem costs.

Extension of Payment Transition for Former Medicare Dependent, Small Rural Hospitals (MDHs)

Due to revisions to the OMB's statistical area delineations, some hospitals lost their rural status and thus risked losing their MDH status unless they could be reclassified as rural under certain criteria. The proposed rule granted a three year transition to the IPPS federal rate to those former MDH hospitals which were in all-urban states and which had not reclassified as rural. In response to comments, CMS has expanded this three year transition to all former MDHs which have not reclassified to rural.

Cost Reporting Regulation Changes

CMS has finalized its 2015 proposed rule to require a provider to include an appropriate claim for a specific item in its cost report in order to receive Medicare reimbursement for the specific item. If it does not appear, reimbursement for the item will not be included in the notice of program reimbursement from the contractor, or in any decision by a reviewing entity or administrative appellate body. CMS will instruct contractors that they must accept one amended cost report filed within one year of the original cost report's due date solely for the purpose of revising the number of Medicaid-eligible days in the hospital's disproportionate share hospital (DSH) claim based on updated Medicaid eligibility information from the state Medicaid agency.

Quality Reporting Program Changes

CMS finalized a new measure to the program for the CY 2018 payment determination and subsequent years – OP-33: External Beam Radiotherapy for Bone Metastases (NQF# 1822) (Web-based): Percentage of patients (all-payer) with painful bone metastases and no history of previous radiation who receive EBRT with an acceptable dosing schedule. CMS will require a modification, requiring that hospitals submit data submission as an aggregate data file via a web-based tool (QualityNet).

Several policy changes also were finalized to align the Hospital Outpatient Quality Reporting (OQR) Program with the Ambulatory Surgical Center Quality Reporting (ASCQR) Program, including changing the deadline for withdrawing from the program to August 31, changing the deadline for submitting a reconsideration request to the first business day on or after March 17 of the affected payment year, and shifting the quarters on which payment determinations are based, which will require a one-time change in the CY 2017 payment determination timeframe to cover three quarters instead of four quarters.

CMS is also removing one measure, OP-15: Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache. CMS continues to explore electronic clinical quality measures for potential future rulemaking.

CMS will consider comments for future rulemaking regarding the ASCQR Program as it relates to Normothermia Outcome, and Unplanned Anterior Vitrectomy. CMS also will not consider Indian Health Service hospital outpatient departments that bill Medicare for ASC services as ASCs for purposes of the ASCQR Program.

CMS will display ASCQR Program data by the NPI or CCN, depending on how data are submitted.