What's Next for the OPPS: A Look at the 2021 Final Rule

December 15, 2020
Webinar FAQ Document

1. **Question** – What are the Healthcare Common Procedure Coding System Codes (HCPCS) for the Hemospray and SpineJack devices?

   Answer – For the Hemospray® Endoscopic Hemostat, HCPCS code C1052, *Hemostatic agent, gastrointestinal, topical,* has been created for reporting.[1] For the SpineJack® System, HCPCS code C1062, *Intravertebral body fracture augmentation with implant (e.g., metal, polymer),* has been created.[2]

2. **Question** – Is modifier JG, *Drug or biological acquired with 340b drug pricing program discount,* required for non-Medicare payers? How about Managed Care?

   Answer – Modifier JG, *Drug or biological acquired with 340b drug pricing program discount,* may be used by non-Medicare payers, including managed care and Medicare Advantage (MA) plans, but each payer may have different requirements for use of this modifier and should be consulted individually. According to the Centers for Medicare & Medicaid Services (CMS) Frequently Asked Questions (FAQ) document, CMS cannot interfere in the contracted payment rates between MA plans and providers.[3]

3. **Question** – What are the status indicators for the procedures that used to be on the Inpatient Only (IPO) List and assigned status indicator C?

   Answer – In addition to the original 266 codes proposed to be removed from the IPO List, CMS added 32 additional codes, for a total of 298 codes no longer assigned to status indicator C, *Inpatient Procedures,* for calendar year 2021. Most of the procedures are considered to be comprehensive services and have been assigned a status indicator of J1, *Hospital Part B services paid through a comprehensive APC*. Thirty-four (34) of these procedures are add-on services which are packaged into other primary procedures and therefore have been assigned a status indicator of N, *Items and Services Packaged into APC Rates*. Two codes represent conditionally packaged services which have been assigned a status indicator of Q1, *STV-Packaged Codes*, and one code has been assigned a status indicator T, *Procedure or Service, Multiple Procedure Reduction Applies*. A downloadable report of all status indicator changes along with reimbursement impacts can be found on the vitalware main dashboard and is titled "CPT-HCPCS Code Updates 2021-Q1". For attendees who aren't

[1] Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs, "Traditional Device Pass-through Applications", page 357, available here: https://public-inspection.federalregister.gov/2020-26819.pdf

[2] Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs, "Traditional Device Pass-through Applications", page 374, available here: https://public-inspection.federalregister.gov/2020-26819.pdf

[3] Medicare Fee For Service Program, Billing 340B Modifiers under the Hospital Outpatient Prospective Payment System (OPPS), "Frequently Asked Questions", page 4, available here: https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps/downloads/billing-340b-modifiers-under-hospital-opps.pdf

current vitalware clients, a list of the codes with their new status indicators is located in Table 48 in the CY 2021 Outpatient Prospective Payment System (OPPS) Final Rule.[4]

4. **Question** – Wouldn't we use modifier CG, *Policy criteria applied,* for device intensive procedures that don't use a device identified by a HCPCS code?

   Answer – You may use modifier CG to bypass the claims processing edit that requires a device HCPCS code for the procedure, effective for dates of service on or after January 1, 2019, but only in circumstances that describe situations in which a device may not be required.[5]

5. **Question** – Could you provide an update on the site neutrality with respect to payment reductions or changes related to modifier PO, *Services, procedures and/or surgeries provided at off-campus provider-based outpatient departments,* and PN, *Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital*?

   Answer – CY 2019 was the first year where the claims data used for rate-setting purposes contained modifier PN, *Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital*. Because these services are not paid under the OPPS, CMS removed them from the claims used for setting rates.[6] CMS is continuing their current reimbursement policy for drugs at the Average Sales Price (ASP) minus 22.5% for 340B-acquired drugs for both excepted and non-excepted Provider Based Departments (PBDs).[7] For 2021, CMS is continuing with their current clinic and emergency department visit payment policies. There are very few changes, as there is continuing litigation regarding the volume control method used for clinic visit services furnished by non-excepted, off-campus PBDs. CMS stated that they did not believe it was appropriate to make a change to their 2-year phase-in of the policy. CMS is continuing with utilizing a Medicare Physician Fee Schedule (MPFS) equivalent payment rate for HCPCS code G0463, *Hospital outpatient clinic visit for assessment and management of a patient* at 40% of the OPPS rate when furnished in non-excepted, off-campus PBDs. [8]

6. **Question** – Is CMS allowing a grace period for code changes since they were late in releasing HCPCS codes and the OPPS Final Rule?

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[4] Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs, "CY 2021 Proposal to Eliminate the IPO List", page 614 and pages 625-641, available here: https://public-inspection.federalregister.gov/2020-26819.pdf

[5] Medicare Claims Processing Manual, Publication 100-04, Chapter 4, Section 61.2

[6] Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs, "Final Data Development and Calculation of Costs Used for Ratesetting", page 36, available here: https://public-inspection.federalregister.gov/2020-26819.pdf

[7] Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs, "Alternative Proposal to Continue Policy to Pay ASP Minus 22.5 Percent", page 515, available here: https://public-inspection.federalregister.gov/2020-26819.pdf

[8] Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs, "OPPS Payment for Hospital Outpatient Visits and Critical Care Services", pages 554-561, available here: https://public-inspection.federalregister.gov/2020-26819.pdf

Answer – No, there is no grace period because the codes were published late. The Administrative Simplification portion of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) established that the codes used were to be the codes in effect on the date of service, which eliminated any grace period.[9]

7. **Question** – Is there any indication of waivers extending past the calendar year for the public health emergency for site of service, telehealth, etc.?

   Answer – The Declaration of a Public Health Emergency (PHE) due to the Coronavirus Disease 2019 (COVID-19) pandemic was renewed on October 23, 2020 and again on January 7, 2021.[10] Under the OPPS, the flexibility of direct supervision by audio/visual means for pulmonary rehabilitation services, cardiac rehabilitation services and intensive cardiac rehabilitation services has been expanded to be the end of the calendar year during which the PHE ends or December 31, 2021, as well as permanently changing the supervision level of non-surgical extended duration therapeutic services (NSEDTS) to general supervision.[11]

[9]U.S. Department of Health & Human Services, "Health Insurance Portability and Accountability Act of 1996", available here: https://aspe.hhs.gov/report/health-insurance-portability-and-accountability-act-1996

[10] U.S. Department of Health & Human Services, "Renewal of Determination That A Public Health Emergency Exists", available here: https://www.phe.gov/emergency/news/healthactions/phe/Pages/covid19-2Oct2020.aspx

[11] Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs, "Changes in the Level of Supervision of Outpatient Therapeutic Services in Hospitals and Critical Access Hospitals (CAHs)", pages 641-651, available here: https://public-inspection.federalregister.gov/2020-26819.pdf