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What's Next for the OPPS

A Look at the 2021 Final Rule

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RHIT, CCS, CCS-P, CHRI, CIRCC

Updates Affecting OPPS Payment

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Updates Affecting OPPS Payment

- Final OPPS Conversion Factor of $82.797 – Up from $80.784 for 2020
- Predicted increase of 2.4% in OPPS payments to providers
- The 2% reduction will still apply to hospitals not meeting quality reporting requirements – CF of $81.183
- The 7.1% adjustment for rural sole community hospitals will continue
- Adjustment for cancer hospitals will continue (payment-to-cost ratio equal to 0.89)

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Updates Affecting OPPS Payment

- IPPS wage index adjustments will be used to calculate OPPS adjustments on 1/1/2021
- Using revised delineations per the OMB (built from 2010 census results)
- Wage index decreases will be capped at 5%; no cap on increases
- The 7.1% adjustment for rural sole community hospitals will continue
- Adjustment for cancer hospitals will continue (payment-to-cost ratio equal to 0.89)

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Updates Affecting OPPS Payment

- Hospital outlier payments will be triggered when a hospital's cost of furnishing a service exceeds 1.75 times the APC payment amount AND exceeds fixed dollar amount of $5,300 (up from $5,075 for CY 2020)

- Outlier payments continue to be calculated as 50% of the amount by which the cost of the service exceeds 1.75 times the APC payment amount

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Updates to Comprehensive APCs (C-APCs)

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Comprehensive APC Refresher

Excluded services

- Mammography
- Ambulance,
- Brachytherapy
- Pass-through drugs and devices
- Self-administered drugs
- Corneal tissue acquisition
- Therapy services used for wound care
- Hepatitis B, influenza and pneumococcal vaccines
- New technology services
- COVID-19 treatments approved in outpatient setting

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Comprehensive APC Refresher

- **Multiple procedures with ‘J1’ status indicator may qualify for complexity adjustment (Addendum J)**
  - Procedure assigned to next higher cost C-APC within a clinical family
    - CPT code 11044 (debridement of bone) has an APC of 5072 and national payment rate of $1,407; when 11044 or 20220 (bone biopsy) is added to the encounter, claim qualifies for APC 5073 with national payment rate of $2,370

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Comprehensive APC Refresher

- **When a specific combination of services is performed, all other OPPS payable services and items reported on the claim are deemed adjunctive (SI=J2)**
  - Comprehensive Observation Services
  - Ancillary Outpatient Services When Patient Dies
  - Excluded services include procedures assigned to a New Technology APC

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Changes to C-APCs

Two new C-APCs are being proposed for CY 2021

- APC 5378 – Level 8 Urology and Related Services
  - Result of adding an additional level of service to eliminate large cost gaps
  - Penile prosthesis and urinary sphincter procedures are being reassigned from 5377 to 5378
  - Reimbursement decrease from $18,258 to $17,574
- APC 5465 – Level 5 Neurostimulator and Related Procedures
  - Result of adding additional levels of service to both of these groups for "smoother distribution of the costs between the different levels…"
  - CY 2021 reimbursement $29,445
  - APC 5463 and 5464 are decreasing as a result

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Changes to Packaged Items & Services

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New Category of Lab Tests Excluded From Packaging

Cancer-related protein-based MAAA services that are "generally unrelated" to the OPPS encounter will be paid under CLFS

- 81490 – Assay of 12 biomarkers for rheumatoid arthritis
- 81500 - Assay of CA-125 and He4 for ovarian oncology
- 81503 – Assay of CA-125, apo A1, beta-2 macroglobulin, transferrin and pre-albumin for ovarian oncology
- 81535/81536 – Live tumor cell culture and chemo drug response for gynecologic oncology
- 81539 – Assay of total PSA, free PSA, intact PSA and hK2 for prostate oncology
- Future cancer-related protein-based MAAAs that will be developed in the future

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Unclassified Blood Products

HCPCS code P9099 assigned status indicator of “R” for CY 2021

- Payment rate of $7.79 per unit
- Proposal allows for some reimbursement but also encourages manufacturers of these blood products to seek out new HCPCS codes for their products
- VERY important that accurate cost information be reported in the coming years to ensure appropriate rate setting for these potentially costly products

Updates to OPPS APC-Specific Policies

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Changes to New Technology APC Groups

HCPCS	Description	2021 APC	2021 $	2020 APC	2020 $
0398T	MRgFUS ablation of intracranial lesion for movement disorder	5463	$11,236	1575	$12,501
C9770	Vitrectomy with subretinal injection of pharmacologic agent (Luxturna)	1561	$3,251	N/A	N/A
C9751	Bronchoscopy with lesion ablation by microwave therapy	1562	$3,751	1571	$8,251
P9100	Pathogen test for platelets	5732	$34	1494	$36

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IDx-DR Software

HCPCS Code 92229

- APC 5733
- Status Indicator S
- APC reimbursement for 2021 is $55.56

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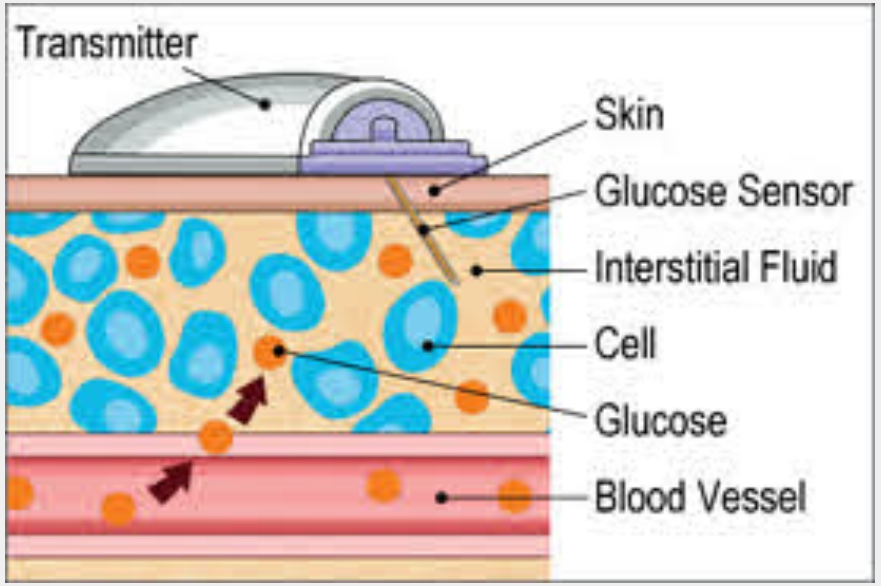
Implantable Interstitial Glucose Sensor System



0446T (insertion of sensor)

0448T (replacement of sensor)

- Reassigned from 5053 to 5054
- APC reimbursement for CY 2021 $1,715 up from $497 for CY 2020

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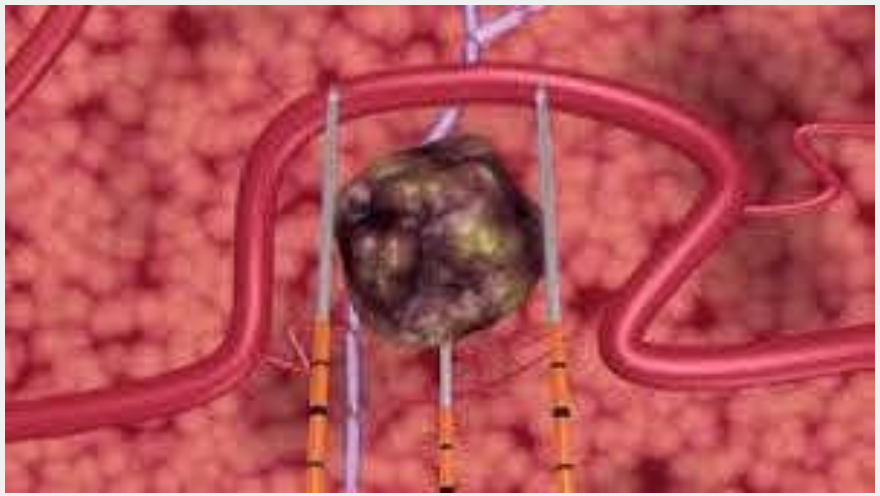
Irreversible Electroporation (NanoKnife®)



0600T (percutaneous ablation)

0601T (open ablation)

- Reassigned from 5361 to 5362
- APC reimbursement for CY 2021
  $8,908 up from $4,834 for 2020

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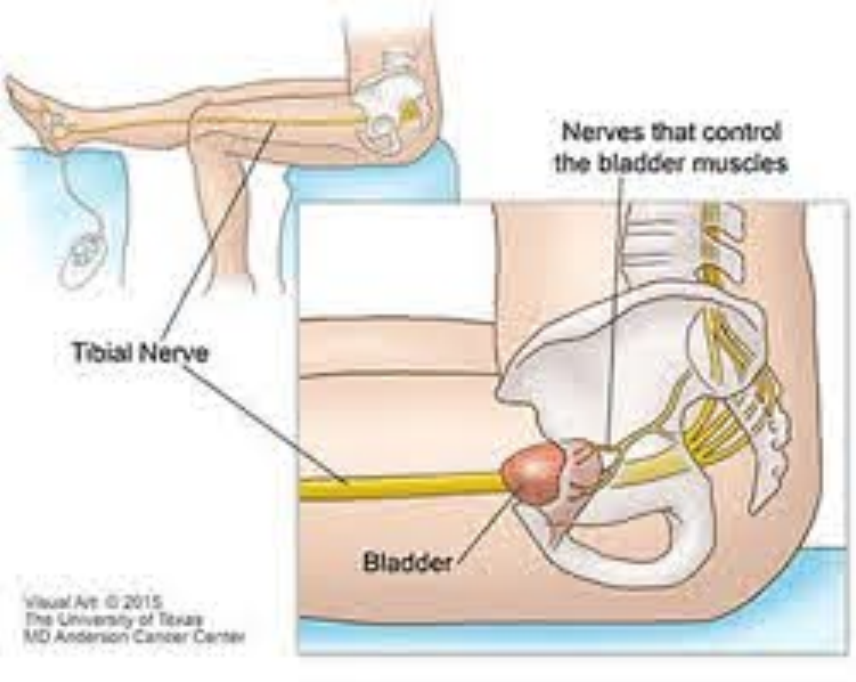
Percutaneous Tibial Nerve Stimulation



0587T (device insertion)

0588T (device revision or removal)

- Reassigned from 5442/5441 to 5462/5461
- APC reimbursement for CY 2021 $6,161/$3,275 up from $652/262 for CY 2020

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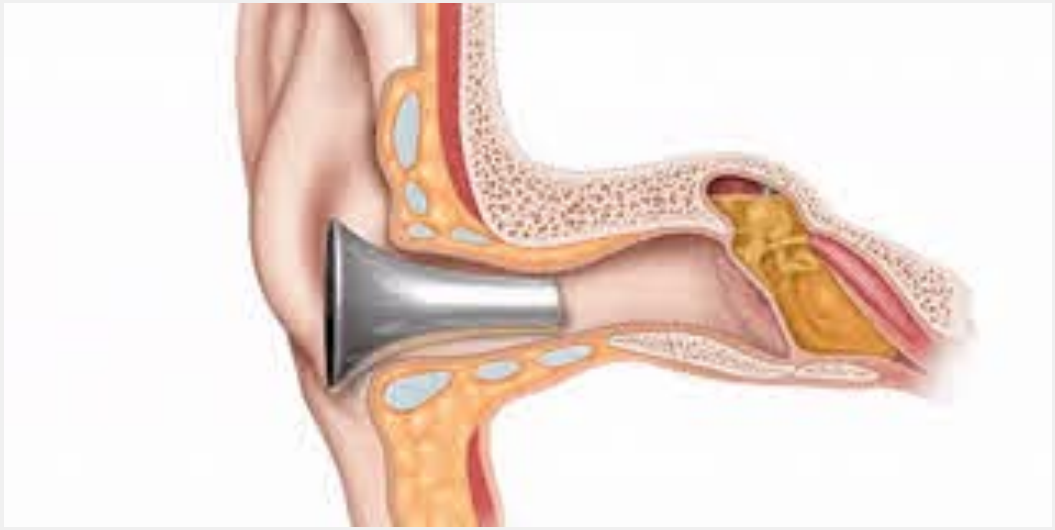
Tympanostomy with Automated Tube



0583T

- Reassigned from not payable to APC 5163
- APC reimbursement for CY 2021 $1,353

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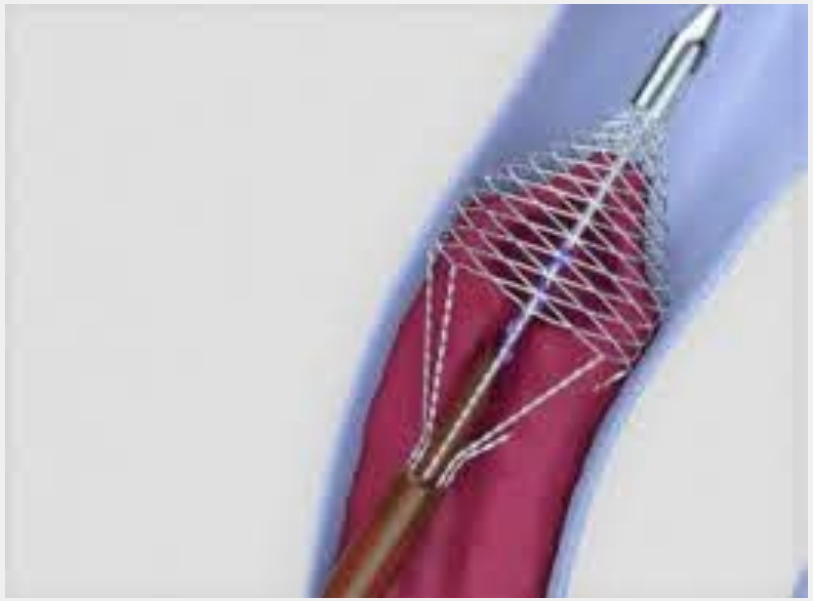
Venous Mechanical Thrombectomy



37187

- Reassigned from APC 5192 to 5193
- APC reimbursement for CY 2021
  $10,043 up from $4,954 in CY 2020

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Final Status Indicator Assignments for Remote Services

No change in SI assignments:

Remote physiological monitoring

- 93264, 93268, 93297, 93298, 99091, 99457, 99458, 99474

- **Virtual check-ins**
  - G2010, G2012
- **E-visits**
  - 98970, 98971, 98972, 99421, 99422, 99423, G2061, G2062, G2063
- **Telephone E/M services**
  - 98966, 98967, 98968, 99441, 99442, 99443
- **Medication therapy management**
  - 99605, 99606

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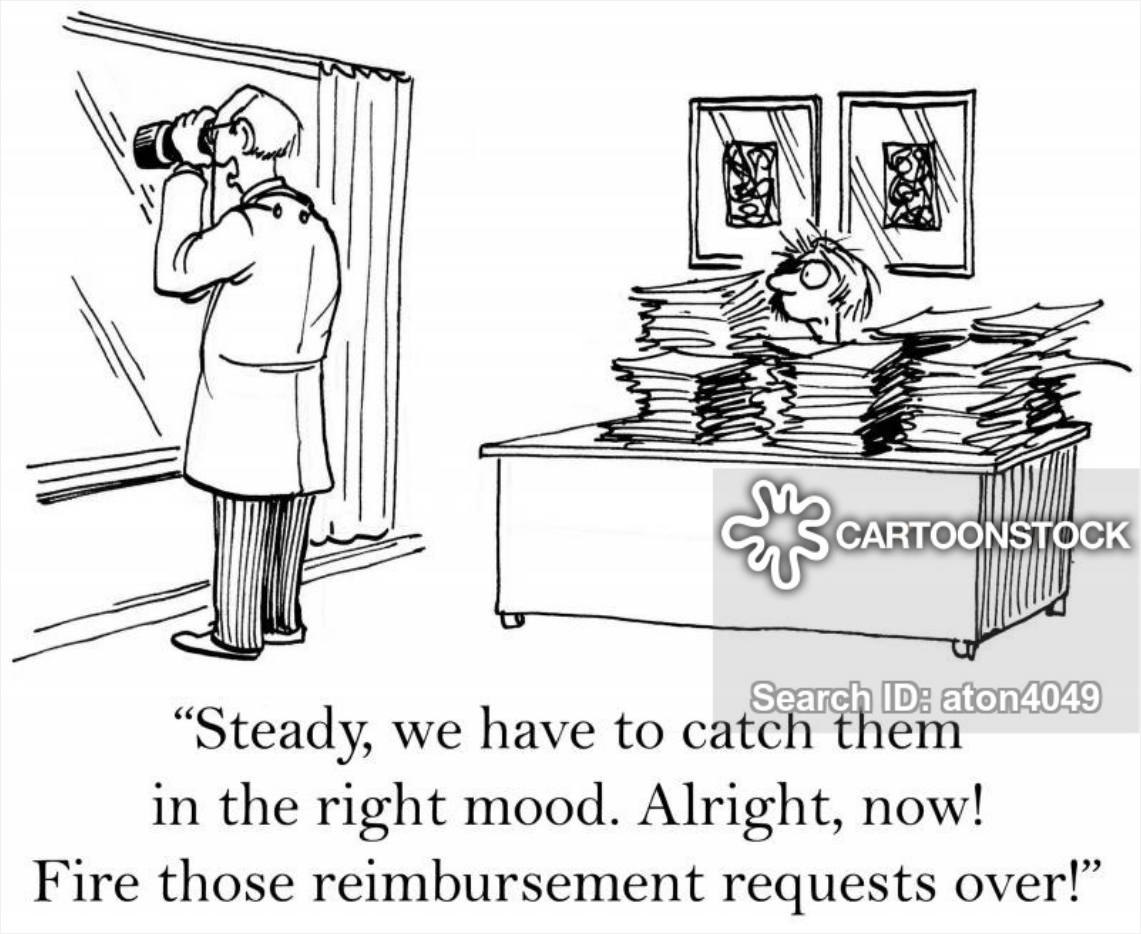
OPPS Payment For Devices



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Pass-Through Status for Devices

Seven Devices with Pass-Through Status through 2021

- Surefire® Spark™ Infusion System – HCPCS Code C1982
- Optimizer® System – HCPCS Code C1824
- AquaBeam® System – HCPCS Code C2596
- AUGMENT® Bone Graft – HCPCS Code C1734
- CustomFlex ARTIFICIALIris® - HCPCS Code C1839*
- Barostim Neo™ - HCPCS Code C1823*
- Exalt™ Model D Single-Use Duodenoscope – HCPCS code C1748*

* Approved under the Breakthrough Device Alternative Pathway

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Pass-Through Status for Devices

New device with pass-through status, beginning January 1, 2021

- Hemospray® Endoscopic Hemostat
- SpineJack® Expansion Kit

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Device-Intensive Procedures

CMS does not produce a list of specific device-to-procedure and procedure-to-device edits

- Any device on the approved list will bypass edit
- CMS expects hospitals to code correctly for procedures and devices
- Full list of device-intensive procedures found in Addendum P or in VitalKnowledge

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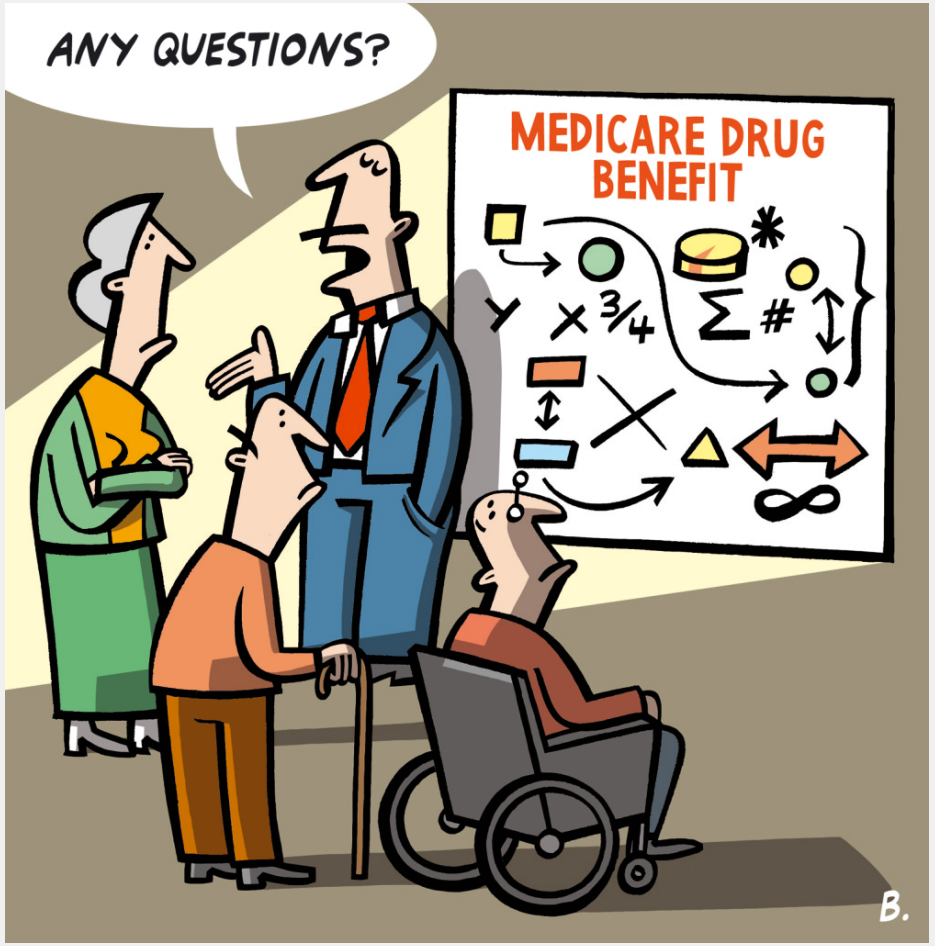
Drugs, Biologicals & Radiopharmaceuticals



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Drugs, Biologicals, & Radiopharmaceuticals

There are 68 drugs and biologicals with new or continuing pass-through status for Q1 of 2021

- Status Indicator “G”
- Paid at ASP + 6% for at least two years but not more than three years or at WAC + 3% if ASP data is not available
- Biosimilars paid at ASP + 6% of reference product’s ASP
- Payment rates updated on a quarterly basis
- See VitalKnowledge or Table 38 for complete list of drugs with pass-through status for Q1 of 2021

Drugs and Biologicals with Expiring Pass-Through Status on 12/31/2020

HCPCS Code	Long Description	2021 SI	2021 $$
J0567	Injection, cerliponase alfa, 1 mg	N	$0
J0599	Injection, C-1 esterase inhibitor (human), (Haegarda), 10 units	K	$9.92
J1628	Injection, guselkumab, 1 mg	K	$93.12
J3316	Injection, triptorelin, extended-release, 3.75 mg	K	$3,044.01
J7345	Aminolevulinic acid HCl for topical administration, 10% gel, 10 mg	K	$1.53
J9153	Injection, liposomal, 1 mg daunorubicin and 2.27 mg cytarabine	K	$197.79
J9203	Injection, gemtuzumab ozogamicin, 0.1 mg	K	$205.38
J9229	Injection, inotuzumab ozogamicin, 0.1 mg	K	$2,341.50

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Pass-Through Packaging Threshold

Packaging threshold for CY 2021 will remain $130, which is the same as CY 2020

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Alternative Payment Methodology for 340B Drugs

Non-pass-through drugs purchased under 340B program will continue to be paid at ASP minus 22.5% for 2021

- Modifier JG should be assigned to 340B drugs by OPPS facilities
- Modifier use will trigger payment reduction
- Modifier TB should be assigned to 340B drugs by facilities that are not subject to the payment reduction
  - No payment reduction will result from modifier use
  - For use by rural SCHs, children's hospitals and PPS-exempt cancer hospitals

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Alternative Payment Methodology for 340B Drugs

- Modifier requirements and payment reduction applies only to drugs with status indicator of “K”
- Vaccines and pass-through drugs are excluded
- Non-OPPS facilities are excluded such as critical access hospitals and Maryland hospitals
- Does apply to non-excepted HOPDs as of 2019
- DC District Court sided with CMS on appeal

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Skin Substitute Products

Due to concern for volatility in pricing of skin substitutes, CMS is still reviewing alternative methodologies for reimbursing for wound care that uses skin substitute(s)

- Lump sum payment for each wound treated
- Single APC for all skin substitute applications
- Comprehensive APC assignment with a potential complexity adjustment when multiple wounds require treatment
- Delayed implementation for any proposed reimbursement change

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Skin Substitute Products

Synthetic products will now be included in the CMS description of skin substitutes

- New code, effective 7/1/20: C1849, Skin substitute, synthetic
  - Assigned to the high-cost group
- New definition: Skin substitutes are defined as a category of biological and synthetic products that are most commonly used in outpatient settings for the treatment of diabetic foot ulcers and venous leg ulcers
- Skin substitute products do not actually function like human skin that is grafted onto a wound; they are not a substitute for a skin graft. Instead, these products are applied to wounds to aid wound healing and through various mechanisms of action they stimulate the host to regenerate lost tissue…
- Definition does NOT include bandage or standard dressings

Partial Hospitalization Program

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Partial Hospitalization Program

CMHCs providing 3 or more services per day will continue to be reimbursed under APC 5853

- CY 2021 reimbursement rate of $139.75
- Reported costs from CMHCs have continued to decrease

Hospital-based PHP providers providing 3 or more services per day will continue to be reimbursed under APC 5863

- CY 2021 reimbursement rate of $260.49

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Partial Hospitalization Program

PHP Utilization Monitoring

- CMS will continue to monitor patients who receive only 3 services per day in PHP Program
- CMS will also continue to monitor the number individual therapy services provided
- Reminder the PHP services require 20 hours per week

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Changes to Inpatient Only List

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Changes to Inpatient Only List

Inpatient Only List will be phased out over a 3-year period, beginning on January 1, 2021

- 266 Musculoskeletal procedures,16 panel-recommended procedures, and 18 anesthesia code will be first group of services removed (Tables 48 in the Final Rule)
- The 2-year exemption on site-of-service claim denials will continue
- CMS plans to issue guidance on appropriate site of service selection for educational purposes only

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Short Inpatient Hospital Stays

RAC Review Exemption

- Procedures newly removed from the IPO list will have an exemption period from RAC Review
  - Exemption period will be **indefinite** (sort of)
  - Exemption will end when procedure is found to be more commonly performed on an OP basis
  - Exemption applies to patient status only
  - Can still be reviewed by BFCC-QIO or RAC for medical necessity and for education
  - Not to be used to determine a hospital's compliance with the 2-midnight rule

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Changes to Inpatient Only List

It is a misinterpretation of CMS payment policy for providers to create policies or guidelines that establish the outpatient setting as the baseline or default site of service for a procedure based on its removal from the IPO list or the elimination of the IPO list.

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Non-recurring Policy Changes

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Changes in Supervision Levels

Level of supervision required for Non-Surgical Extended Duration Therapeutic Services (NSEDTS) permanently changed to general for the duration of the service

- Due to COVID-19 PHE, NSEDTS temporarily have general supervision requirements for the entire service
  - Previously these services required direct supervision during the initiation of the procedure
- Proposal would not preclude hospitals from requiring a higher level of supervision
- Hospitals must continue to comply with all local laws and CoPs

Changes in Supervision Levels

Proposal to permanently allow direct supervision of pulmonary and cardiac rehab services using interactive telecommunications technology

- Physician must maintain a “real-time” presence via audio/video technology
- Policy will continue through the end of the calendar year in which the PHE ends or December 31, 2021, whichever is later

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Method to Control Unnecessary Increases in Hospital OP Services

Clinic visits provided in excepted off-campus provider-based clinics will be reimbursed at the Physician Fee Schedule (PFS) rate

- Will apply to HCPCS code G0463, Outpatient clinic visit, when reported with modifier PO
  - For 2021, reimbursement rate will be equal to 40% of reimbursement under OPPS
    - $47.50 for Q1 of 2021
  - Non-budget neutral change
  - CMS prevailed on appeal to the D.C. District Court

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Prior Authorization Process

Two new categories of services that will require prior authorization on or after 7/1/2021

- Cervical Fusion with Disc Removal
  - 22551 – *Fusion of spine bones with removal of disc at upper spinal column, anterior approach, complex, initial*
  - *22552 – Fusion of spine bones with removal of disc in upper spinal column below second vertebra of neck, anterior approach, each additional interspace*

- Implanted Spinal Neurostimulators
  - 63650 – Implantation of spinal neurostimulator electrodes, accessed through the skin
  - 63685 – Insertion or replacement of spinal neurostimulator pulse generator or receiver
  - 63688 – Revision or removal of implanted spinal neurostimulator pulse generator or receiver

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Prior Authorization Process

Botox Injections

CPT codes 64612 64615 J0585 J0586 J0587 J0588

Panniculectomy

CPT codes 15830 15847 15877

Vein Ablation

CPT codes 36473 36474 36475 36476 36478 36479 36482 36483

Rhinoplasty

CPT codes 20912 21210 30400 30410 30420 30430 30435 30450 30460 30462 30465 30520

Blepharoplasty

CPT codes 15820 15821 15822 15823 67900 67901 67902 67903 67904 67906 67908 67911

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Prior Authorization Process

If claim does not meet preauthorization requirements, claim and all associated services will be denied

- Decision cannot be appealed, but facility may resubmit more information to the contractor (no limit to resubmissions)
- Decisions will be made in 10 business days or 2 for expedited requests (beneficiary's health at risk)

Hospital responsible for preauthorization

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Prior Authorization Process

Unique Tracking Number (UTN) must be included on claims

Process began on July 1, 2020

CMS will perform a semi-annual review; hospitals meeting 90% compliance will be exempted

- Will take 90 days for exemption to take effect
- Hospitals will be notified at least 60 days prior

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Hospital outpatient quality reporting program

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Changes to Hospital OQR Program

Removal of Measures

- No measures are being removed at this time

Delay of Measures

- Continued delay in implementation of one grouped measure until further notice
  - OP-37a-e – Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems Survey (OAS CAHPS)

New Measures

- No new measures are being added at this time

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Measures Retained for CY 2023 Payment Determination

Measure Name
OP-2: Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival
OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention
OP-8: MRI Lumbar Spine for Low Back Pain
OP-10: Abdomen CT – Use of Contrast Material
OP-13: Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low-Risk Surgery
OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients
OP-22: Left Without Being Seen
OP-23: Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT or MRI Scan Interpretation Within 45 Minutes of ED Arrival
OP-29: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

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Measures Retained for CY 2023 Payment Determination

Measure Name
OP-31: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery *
OP-32: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
OP-35: Admissions and ED Visits for Patients Receiving Outpatient Chemotherapy
OP-36: Hospital Visits after Hospital Outpatient Surgery

* Submission of data is voluntary for this measure

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Submission Deadlines for Quality Reporting

Patient Encounter Quarter	Submission Deadline
Q2 2021 (April through June)	11/1/2021
Q3 2021 (July through September)	2/1/2022
Q4 2021 (October through December)	5/1/2022
Q1 2022 (January through March)	8/1/2022

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Hospital Quality Star Rating Program

- Provides a summary of hospital quality information using a system of 1-5 stars
- Program uses measures reported on *Hospital Compare* website
  - Hospital IQR
  - Hospital OQR
  - HRRP
  - HAC Reduction
  - Hospital VBP

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Hospital Quality Star Rating Program

- Star ratings are updated once a year based on one of the previous year's quarters
  - Could be January, April, July, or October data
- VHA hospitals will now be eligible to participate in the program with details outlined through future rules

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Hospital Quality Star Rating Program

- Calculation of measure group scores will now be based on simple averages
- ~~Proposal to stratify only the readmission measure group scores based on % of dual-eligible patients served~~
- Hospitals will be grouped based on the number of measures they submit (3, 4, or 5)
- Hospitals with fewer than 3 measures submitted do not receive a star rating

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Star Quality Program Measure Groups

Measure Group	Examples of Measure	% Weight
Mortality	Death rate for heart attack, CABG, COPD, heart failure, pneumonia, stroke & surgery complication patients	22%
Safety of Care	• Blood infections w/central lines • UTIs w/catheters • Surgical infections from colon surgery & hysterectomies • MRSA blood infections • C. diff infections • Complications following hip/knee replacements	22%
Readmission	• Hospital return days for heart attack, heart failure, COPD & pneumonia patients • Unplanned readmissions (hospital wide)	22%
Patient Experience	Using hospital survey data (inpatients)	22%
Timely & Effective Care	Consolidated from 3 groups to 1 group	12%

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Questions?

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Thank you!

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