

# What's Next for the OPPS

A Look at the 2022 Final Rule

# Disclaimer Statement

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# Jennifer Bishop

RHIT, CCS, CCS-P, CHRI

# Updates Affecting OPPS Payment



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- Final OPPS Conversion Factor of \$84.177 – Up from \$82.797 for 2021
- Predicted increase of 2.0% in OPPS payments to providers
- The 2% reduction will still apply to hospitals not meeting quality reporting requirements – CF of \$82.526
- The 7.1% adjustment for rural sole community hospitals will continue
- Adjustment for cancer hospitals will continue (payment-to-cost ratio equal to 0.90)

# Updates Affecting OPPS Payment



- IPPS wage index adjustments will be used to calculate OPPS adjustments on 1/1/2022
- Using revised delineations per the OMB (built from 2010 census results)
- Wage index decreases will be capped at 5%; no cap on increases
- All changes are budget neutral



# 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 \$6,175 (up from \$5,300 for CY 2021)
- 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

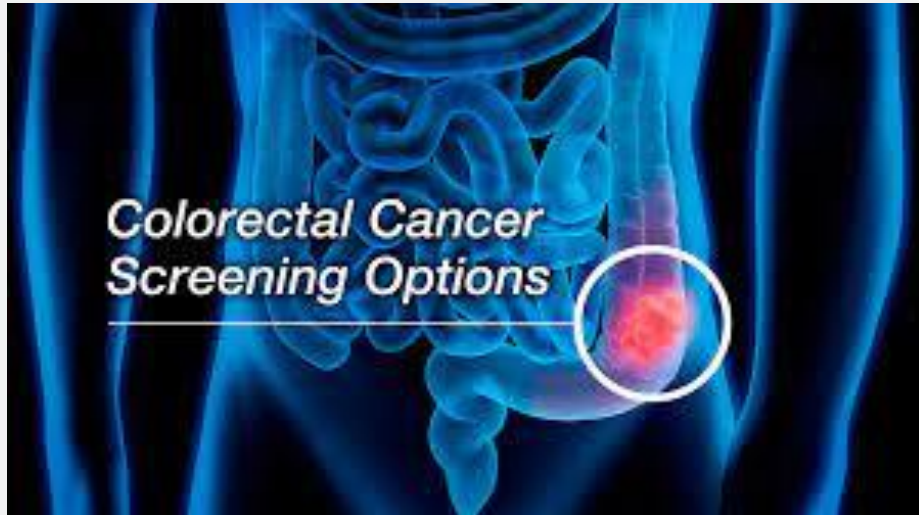
# Updates Affecting OPPS Payment



- Due to effects of COVID-19 PHE on hospital services, CY 2019 claims were used for calculations except for:
  - Offset percentages for 11 device-intensive procedures were calculated using 2020 claims
  - Procedures with no CY 2019 claims data
  - Commenter requests to utilize CY 2020 data



# Changes to Coinsurance



**Phased elimination of coinsurance for screening flexible sigmoidoscopies and colonoscopies that become diagnostic services**

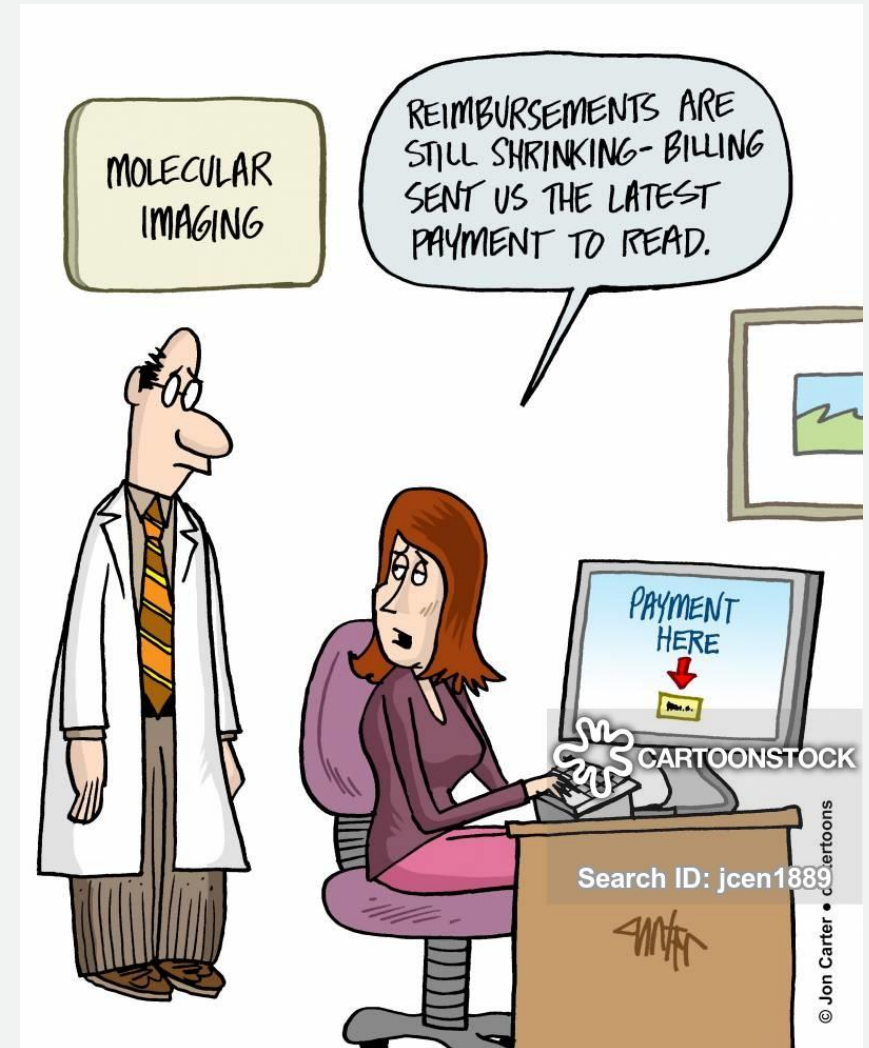
- Append HCPCS modifier PT to the diagnostic procedure code
  - Coinsurance of 20% for CY 2022
  - Coinsurance of 15% for CY 2023
  - Coinsurance of 10% for CY 2027- CY 2029
  - Coinsurance of 0% for CY 2030 and beyond

# Method to Control Unnecessary Increases in Hospital OP Services

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

- Will apply to HCPCS code G0463, Outpatient clinic visit, when reported with modifier PO
  - For 2022, reimbursement rate will be equal to 40% of reimbursement under OPPS
    - \$48.54 for 2022-Q1
  - Non-budget neutral change
  - CMS prevailed on appeal to the D.C. District Court
  - US Supreme Court declined to hear the case

# Updates to Comprehensive APCs (C-APCs)



# Comprehensive APC Refresher

- A classification for the provision of a primary service and all adjunctive services provided to support delivery of the primary service (SI=J1)
- 69 Total C-APCs

# Comprehensive APC Refresher

## Services Excluded from Bundling with J1 Procedures

- Mammography
- Ambulance,
- Brachytherapy seeds
- 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



# 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 \$1,437; when 11044 or 20220 (bone biopsy) is added to the encounter, claim qualifies for APC 5073 with national payment rate of \$2,422

# 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

# Final Changes to C-APCs

- **No New C-APCs are being proposed for CY 2022**
  - Number of C-APCs will remain at 69
- **Current packaging exception for COVID-19 treatments will continue through the end of the current PHE**
  - Treatment must be a drug or biological authorized to treat COVID-19
  - Treatment must be authorized for use in the outpatient setting or not be limited to the inpatient setting

# Updates to OPPS APC-Specific Policies



# Changes to New Technology APC Groups

HCP	HCPCS	Description	2022 APC	2022 \$	2021 APC	2021 \$
	0648T	Quantitative magnetic resonance for analysis of tissue composition (eg, fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained without diagnostic MRI examination of the same anatomy (eg, organ, gland, tissue, target structure) during the same session; single organ	1511	\$951	5523	\$230
	0662T	Scalp cooling, mechanical; initial measurement and calibration of cap	1520	\$1,851	5732	\$34



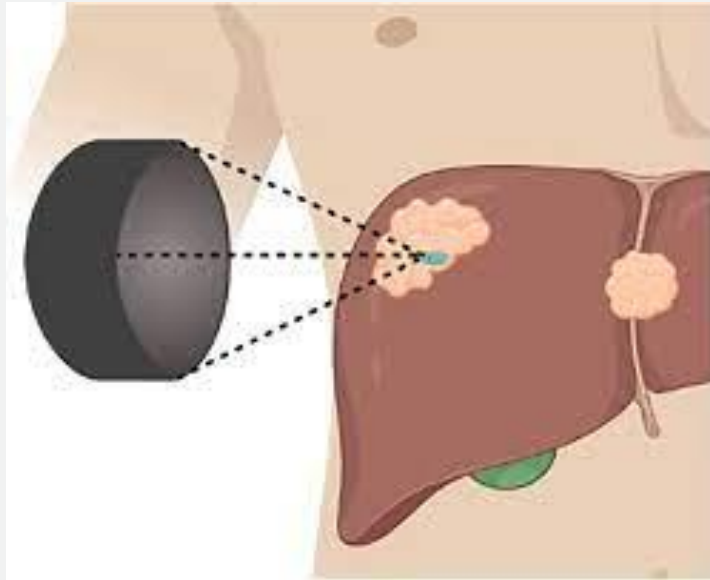
# DARI Motion Procedure



**Code 0693T – Comprehensive full body computer-based markerless 3D kinematic and kinetic motion analysis and report**

- APC 1505
- Status Indicator S
- APC reimbursement for 2022 is **\$350.50**
- Proposed reimbursement was \$143.21

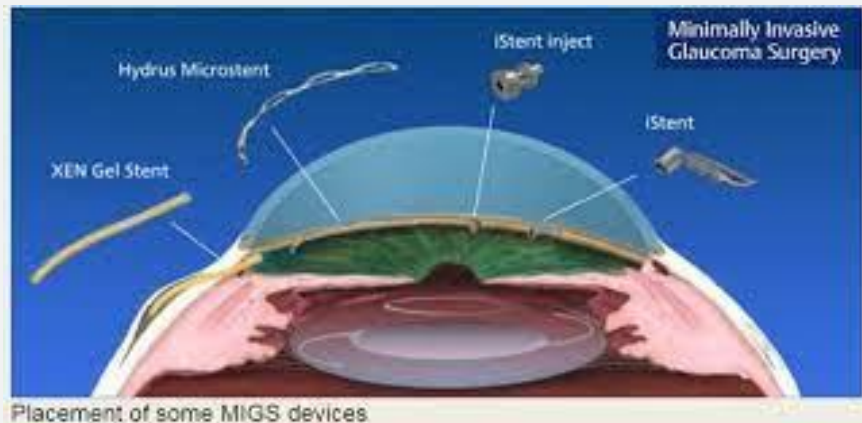
# Histotripsy



## 0686T – Histotripsy of malignant hepatocellular tissue, including image guidance

- APC 1575
- Status Indicator S
- APC reimbursement for 2022 is \$12,500.50
- Proposed reimbursement was \$814.44

# Minimally Invasive Glaucoma Surgery



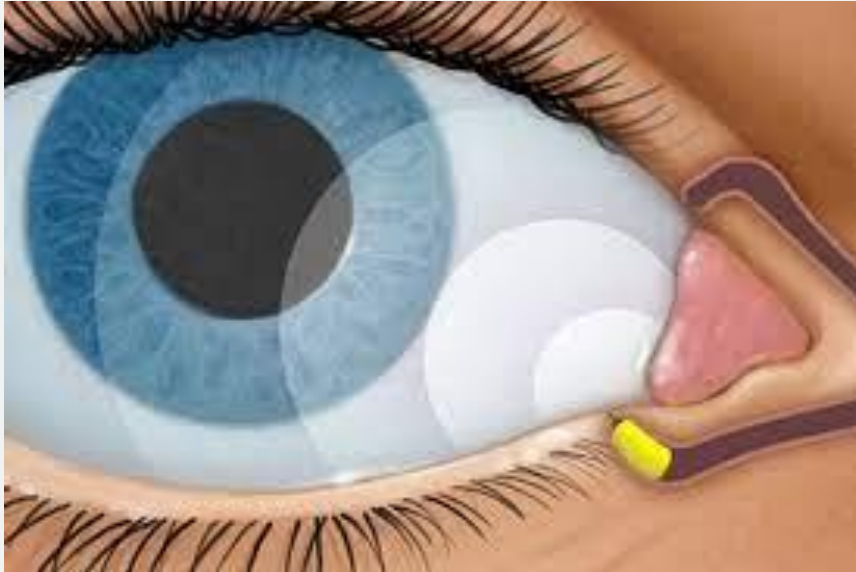
66989 (Complex Cataract Removal with Insertion of Drainage Device)

66991 (Simple Cataract Removal with Insertion of Drainage Device)

0671T (Drainage Device Without Cataract Removal)

- APC assignment of 1526 for 66989/66991
- APC assignment of 5491 for 0671T
- 1526 - \$4,250.50; 5491 - \$2,120.86
- Proposed reimbursement amounts were \$4,018.82 and \$2,131.25

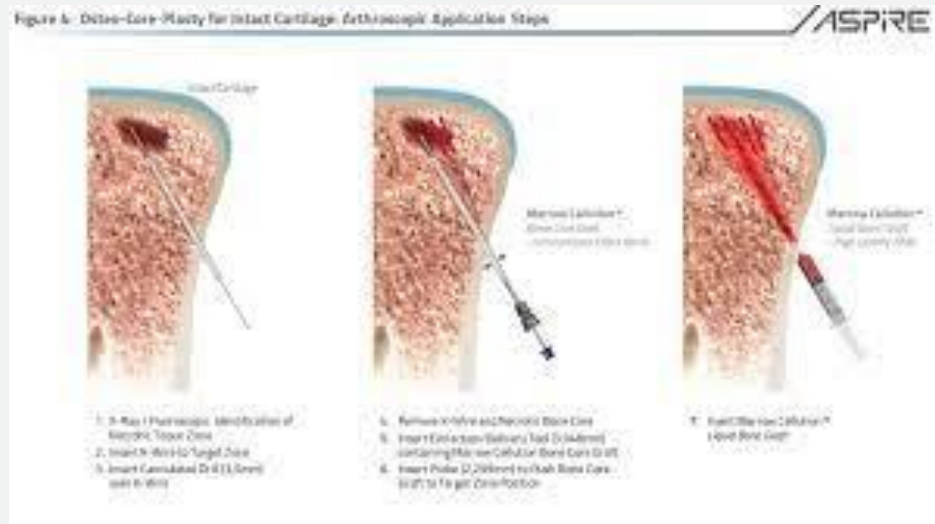
# Lacrimal Ophthalmic Insert into Canaliculus



68841 (replacing 0356T) - Insertion of drug-eluting implant, including punctal dilation when performed, into lacrimal canaliculus, each

- Reassigned from APC 5692 to 5694
- APC reimbursement for CY 2022 **\$325.64** up from \$61.97
- SI remains Q1 despite requests to modify

# Bone Substitute Injection

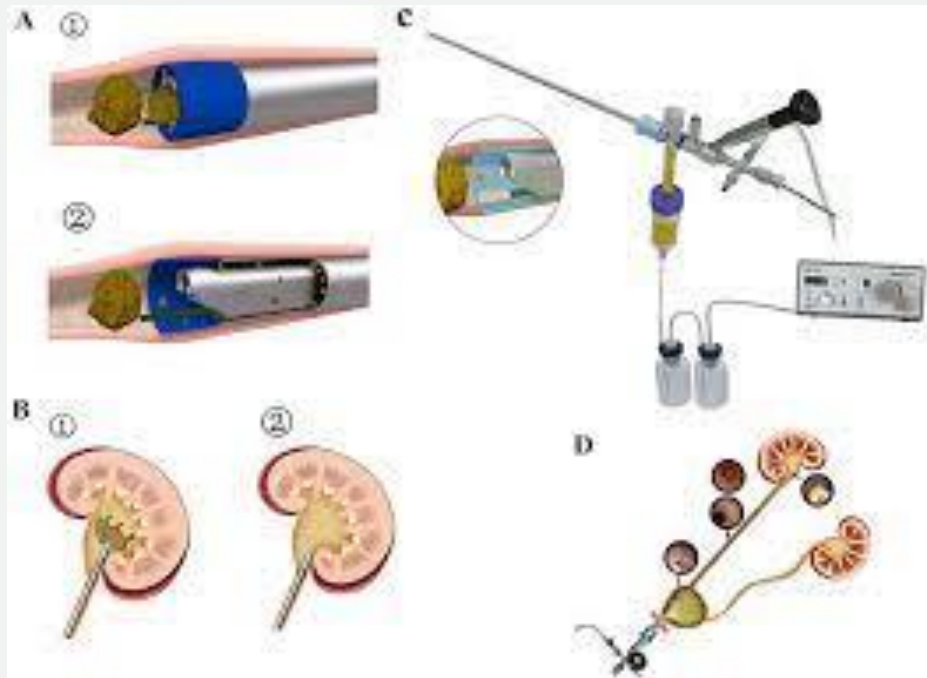


0707T - Injection(s), bone-substitute material into subchondral bone defect, including imaging guidance and arthroscopic assistance for joint visualization

- APC 5113
- SI – J1
- APC reimbursement for CY 2022  
**\$2,892.28**
- Proposed reimbursement was  
\$211.47



# Lithotripsy and Vacuum Aspiration



C9761 - Cystourethroscopy, with ureteroscopy and/or pyeloscopy, with lithotripsy, and ureteral catheterization for steerable vacuum aspiration of the kidney, collecting system, ureter, bladder, and urethra if applicable

- Reassigned from APC 5375 to 5376
- SI remains J1
- APC reimbursement for CY 2022 **\$8,428.82** up from \$4,413.90

# EGD With Pseudocyst Drainage



43240 - Esophagogastroduodenoscopy, flexible, transoral; with transmural drainage of pseudocyst (includes placement of transmural drainage catheter[s]/stent[s], when performed, and endoscopic ultrasound, when performed)

- Reassigned from APC 5331 to 5303
- SI remains J1
- APC reimbursement for CY 2022 **\$5,140.85** up from \$3,080.79

# External ECG Recording



**93242 - External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; recording**

**93243 - ;scanning analysis with report**

- Reassigned to APCs 5733/5734 from 5732/5733
- SI remains Q1
- APC reimbursement for 93242 **\$56.85** up from \$33.84
- APC reimbursement for 93243 **\$115.16** up from \$55.66

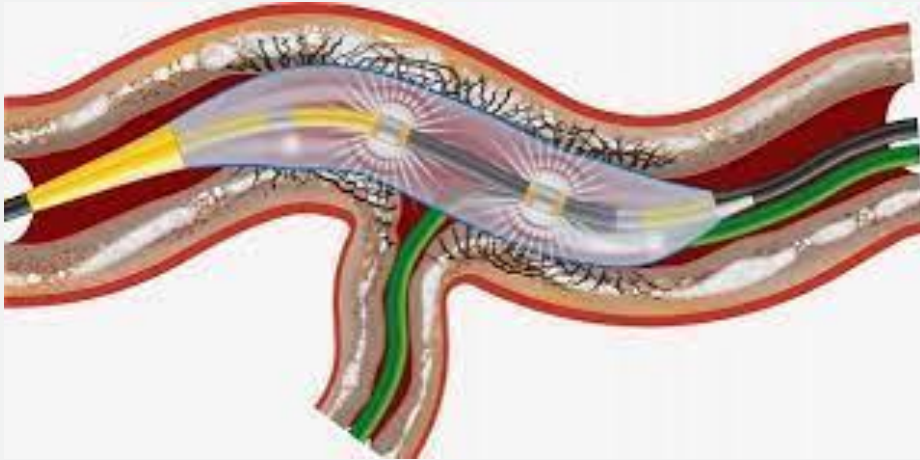
# Sacrospinous Colpopexy



**C9778 - Colpopexy, vaginal; minimally invasive extra-peritoneal approach (sacrospinous)**

- Reassigned to APC 5415 from 5414
- SI remains J1
- APC reimbursement for CY 2022 **\$4,503.49** up from \$2,623.21

# Intravascular Lithotripsy



**C9764 – Intravascular lithotripsy in lower extremity arteries**

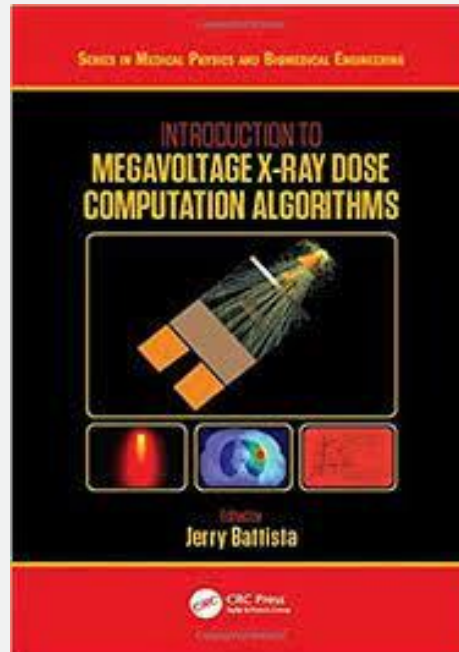
**C9765 – IVL with stent placement**

**C9766 – IVL with atherectomy**

- Reassigned to APCs 5193/5194/5194 from 5192/5193/5193
- SI remains J1
- APC reimbursement for C9764 **\$10,258.49** up from \$4,956.84
- APC reimbursement for C9765/C9766 **\$16,402.31** up from \$10,042.91



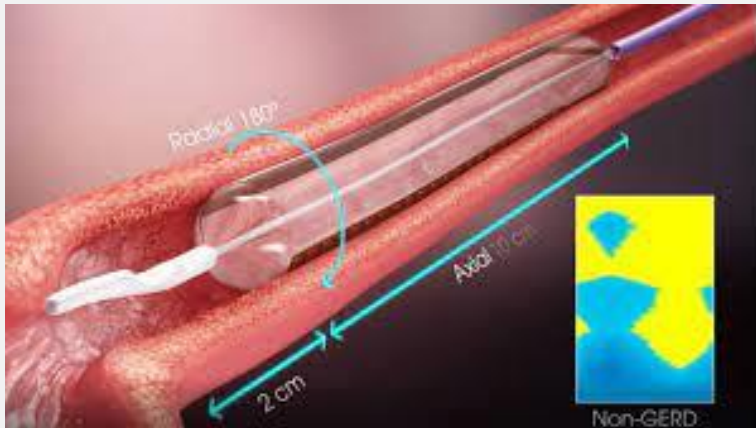
# Medical Physics Dose



76145 - Medical physics dose evaluation for radiation exposure that exceeds institutional review threshold, including report

- Reassigned to APCs 5612 from 5611
- SI remains S
- APC reimbursement **\$345.85** up from \$126.87

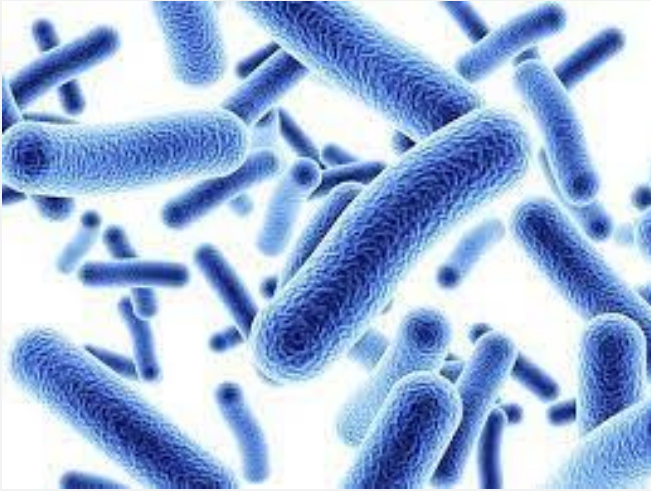
# MiVu™ Mucosal Integrity Testing



**C9777 - Esophageal mucosal integrity testing by electrical impedance, transoral, includes esophagoscopy or esophagogastroduodenoscopy**

- Reassigned to APC 5303
- SI changed for J1 from N
- APC reimbursement **\$3,135.90**; previously was a bundled service

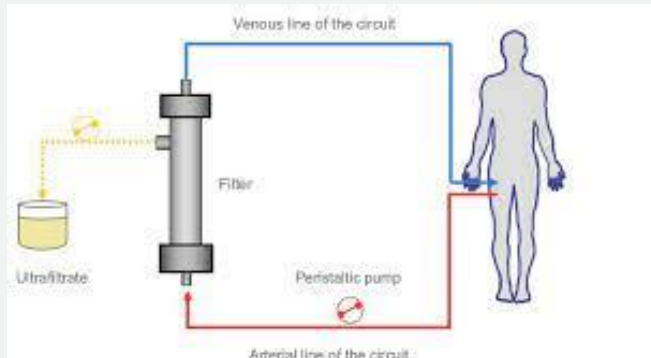
# Pathogen Test for Platelets



## P9100 – Pathogen(s) test for platelets

- Reassigned to APC 5733 from APC 5732
- SI remains S
- APC reimbursement **\$56.85** up from \$33.84

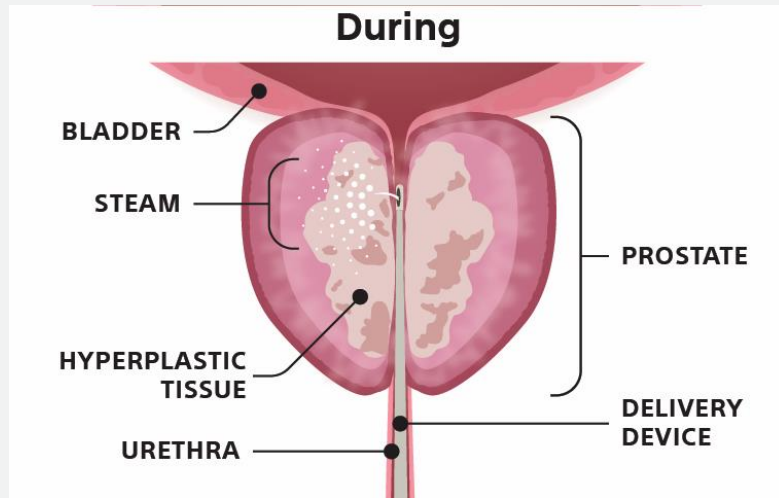
# Therapeutic Ultrafiltration



## 0692T – Therapeutic ultrafiltration

- Assigned to APC 5241
- SI = S
- APC reimbursement **\$405.37**; proposed rule would have excluded the procedure from coverage

# Rezūm Procedure



**53854 – Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy**

- Reassigned to APC 5374 from APC 5373
- SI remains J1
- APC reimbursement **\$3,140.04** up from \$1,792.99

# OPPS Payment For Devices



“Steady, we have to catch them  
in the right mood. Alright, now!  
Fire those reimbursement requests over!”

# Pass-Through Status for Devices

## 11 Devices with Continuing Pass-Through Status

- Surefire<sup>®</sup> Spark<sup>™</sup> Infusion System – HCPCS Code C1982
- Optimizer<sup>®</sup> System – HCPCS Code C1824
- AquaBeam<sup>®</sup> System – HCPCS Code C2596
- AUGMENT<sup>®</sup> Bone Graft – HCPCS Code C1734
- CustomFlex ARTIFICIALIris<sup>®</sup> - HCPCS Code C1839
- Exalt<sup>™</sup> Model D Single-Use Duodenoscope – HCPCS code C1748
- Hemospray<sup>®</sup> - HCPCS code C1052
- SpineJack<sup>®</sup> System – HCPCS code C1062
- Barostim Neo<sup>®</sup> - HCPCS code C1825
- Shockwave C<sup>2</sup> Coronary Intravascular Lithotripsy catheter – C1761
- Remede System – C1823



# Pass-Through Status for Devices

Two Devices Approved for Pass-Through Status for January 1, 2022

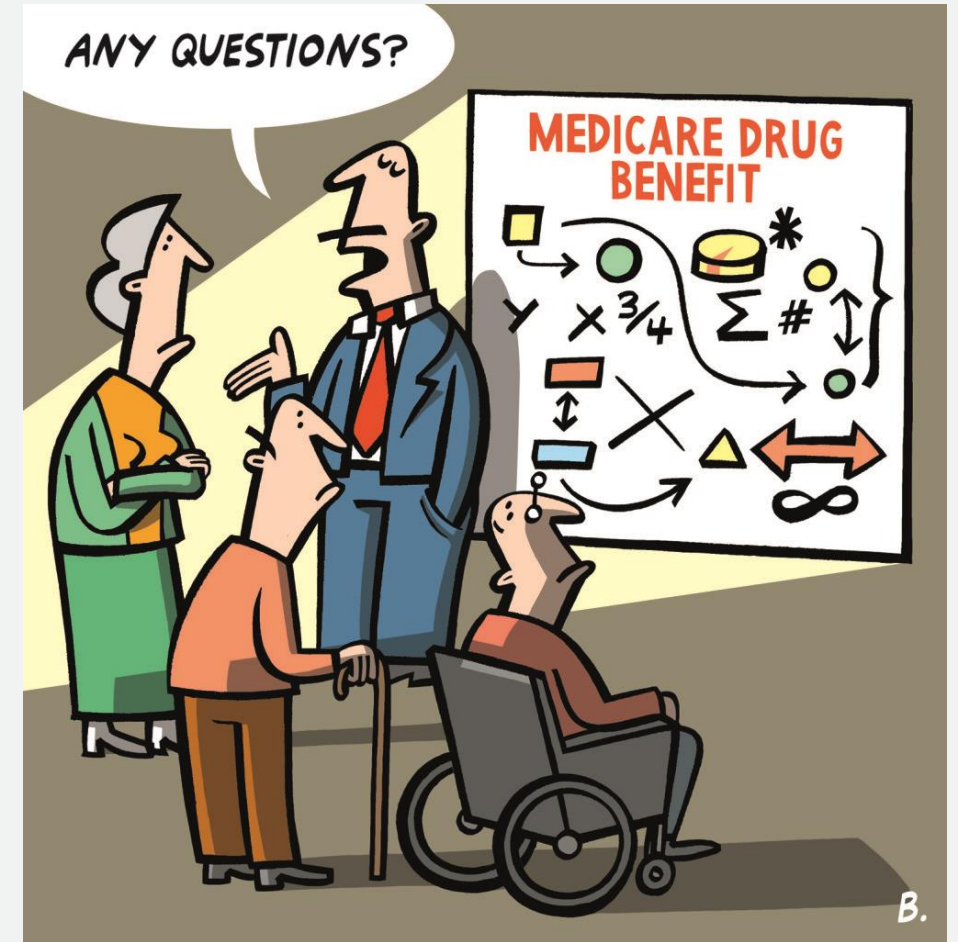
- RECELL® System – HCPCS code C1832
- AngelMed Guardian® System – HCPCS code C1833

# 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

# Drugs, Biologicals & Radiopharmaceuticals



# Drugs, Biologicals, & Radiopharmaceuticals

There are 78 drugs and biologicals proposed for new or continuing pass-through status for Q1 of 2022 – 6 Drugs that would have expired will get continued pass-through payment due to effects of COVID-19 PHE

- 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
- Therapeutic radiopharmaceuticals and blood clotting factors continue to be paid at ASP + 6%
- Payment rates updated on a quarterly basis
- See VitalKnowledge or Tables 38/39 for complete list of drugs with pass-through status for Q1 of 2022

# Pass-Through Packaging Threshold



- Packaging threshold for CY 2022 will remain \$130; rate has been the same for the past three calendar years
- Packaging determinations made once a year
  - Based on 2<sup>nd</sup> Quarter 2021 ASP data from manufacturers

# 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 2022 (No change)**

- 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

# 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
- US Supreme Court has agreed to hear the case during its current session



# Skin Substitute Products

## 17 Skin Substitute Products are Moving from Low-Cost to High-Cost Assignment

Q4167 (Truskin)	Q4182 (Transcyte)	Q4188 (AmnioArmor)
Q4190 (Artacent AC)	Q4193 (Coll-e-Derm)	Q4198 (Genesis Amniotic)
Q4200 (Skin TE)	Q4201 (Matrion)	Q4209 (SurGraft)
Q4211 (AxoBioMembrane)	Q4219 (surgiGRAFT-Dual)	Q4222 (ProgenaMatrix)
Q4232 (Corplex)	Q4237 (Cryo-Cord)	Q4238 (Derm-Maxx)
Q4239 (Amnio-Maxx)	Q4249 (Amniply)	

# Partial Hospitalization Program



# Partial Hospitalization Program

**For CY 2022 only, CMS has instituted a floor for PHP services in order to hold reimbursement steady since reported costs continue to decline**

- CMHCs providing 3 or more services per day will continue to be reimbursed under APC 5853
  - CY 2022 reimbursement rate of \$136.14 is equal to CY 2021 rate
- Hospital-based PHP providers providing 3 or more services per day will continue to be reimbursed under APC 5863
  - CY 2022 reimbursement rate of \$253.76 is equal to CY 2021 rate

# Changes to Inpatient Only List/2-Midnight Rule



# Changes to Inpatient Only List

## Reversal of decision to phase out the Inpatient Only (IPO) List over a 3-year period

- Almost all IPO procedures removed in 2021 will be added back to the IPO list for CY 2022 (293/298 services)
- Five procedures will be removed based on comments received in response to the Proposed Rule
  - 01486 – Anesthesia for total ankle replacement
  - 01638 – Anesthesia for total shoulder replacement
  - 22630 – Lumbar posterior interbody arthrodesis
  - 23472 – Total shoulder replacement
  - 27702 – Total ankle replacement

# Codifying of Criteria Used to Remove Procedures from IPO



- Most outpatient departments are equipped to provide the services to the Medicare population
- The simplest procedure described by the code may be furnished in most outpatient departments
- The procedure is related to codes that CMS has already removed from the IPO list
- A determination is made that the procedure is being furnished in numerous hospitals on an outpatient basis
- A determination is made that the procedure can be appropriately and safely furnished in an ASC and is on the list of approved ASC services or has been proposed by CMS for addition to the ASC list



# Two-Midnight Rule



## RAC Review Exemption

- Procedures on the IPO list are appropriate for IP hospital admission **regardless of expected length of stay**
- Procedures removed from the IPO list will be exempt from “patient status” review for 2 years
  - Can still be reviewed by BFCC-QIO or RAC for medical necessity or education
  - Not to be used to determine a hospital’s compliance with the 2-midnight rule



# **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.**

# Requirements for Hospitals to Make Public a List of Their Standard Charges



# Increased Civil Monetary Penalties for Noncompliance



Source: HHS, [www.hhs.gov](http://www.hhs.gov)

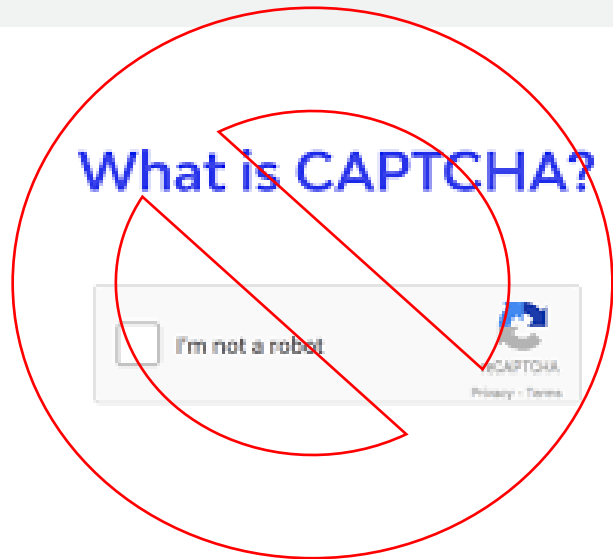
- Hospitals with  $\leq 30$  beds - CMP amount will be \$300 per day
- Hospitals with more than 31 beds— CMP amount will be \$10 per bed per day
  - Amount caps at \$5,550 per day
  - Number of beds will be determined based on most recent cost report

# Facilities Excluded from Rules



- State forensic hospitals will qualify for exemption
  - Defined as a public psychiatric hospital that provides treatment for individuals who are in the custody of penal authorities
  - Will not apply unless treatment is exclusively provided to those patients

# Rules Prohibiting Barriers to Access



- Pricing information must be accessible to automated searches and direct file downloads
- Link must be posted on a publicly available website
- No blocking codes or CAPTCHA allowed

# Hospital outpatient quality reporting program



# Changes to Hospital OQR Program

## Removal of Measures

- OP-2 Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival (2023)
- OP-3 Median Time to Transfer to Another Facility for Acute Coronary Intervention (2023)

## New Measures

- COVID-19 Vaccination Coverage Among Health Care Personnel (2022)
- Breast Cancer Screening Recall Rates (2022)
- STEMI eCQM (voluntary for 2023/required for 2024)
- OP-37a-e – Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems Survey (voluntary for 2023/required for 2024)



# New Quality Measures

- **COVID-19 Vaccination Coverage Among HCP (OP-38)**
  - Denominator: Number of HCP eligible to work for at least 1 day of self-selected week
  - Numerator: Number of HCP who have received complete vaccination course
  - Reported quarterly through the CDC's NHSN web-based surveillance system
- **Breast Cancer Screening Recall Rates (OP-39)**
  - Denominator: Number of Medicare patients who received breast screening service (mammogram or digital breast tomosynthesis) at an OPPS facility
  - Numerator: Number of patients who received a diagnostic mammogram, ultrasound, DBT, or MRI within 45 days of screening service
  - Data will be collected from final claims data

# New Quality Measures

- **ST-Segment Elevation Myocardial Infarction eCQM (OP-40)**
  - Denominator: Number of ER patients 18 years and older diagnosed with STEMI who do not have contraindications to fibrinolytic, antithrombotic, and anticoagulation therapies
  - Numerator: Number of patients who received fibrinolytic therapy within 30 minutes of arrival; or number of patients who received percutaneous coronary intervention (PCI) within 90 minutes of arrival; or number of patients who were transferred to a PCI-capable hospital within 45 minutes of arrival at a non-PCI-capable hospital
  - Reported by the hospital's CEHRT using chart data and submitted to CMS, voluntarily in 2023 with mandatory reporting in 2024

# Measures Retained for CY 2022 Reporting

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

# Measures Retained for CY 2022 Reporting

Measure Name
OP-29: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients
OP-31: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (Voluntary reporting; reporting will be required for 2025)
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
OP-38: COVID-19 Vaccination Coverage Among Health Care Personnel
OP-39: Breast Screening Recall Rates (New measure)

# Radiation Oncology Model



# Radiation Oncology Model Updates

- Performance period will be from January 1, 2022 through December 31, 2026
- Program will NOT apply to RT providers in Maryland, Vermont, or US Territories; ASCs; CAHs; exempt cancer hospitals; facilities participating in the Pennsylvania Rural Health Model (PARHM) <https://innovation.cms.gov/initiatives/pa-rural-health-model> ; HOPDs participating in the Community Transformation Track of the Community Health Access and Rural Transformation (CHART) model <https://innovation.cms.gov/innovation-models/chart-model>
- Facilities may opt out due to low volume (fewer than 20 episodes in the most recent year with available claims data)

# Included Cancer Types



- Must be commonly treated with radiation
- Must be associated with current ICD-10 codes that have pricing stability
- Must NOT be determined to be inappropriate for inclusion in model
- Liver cancer proposed for removal



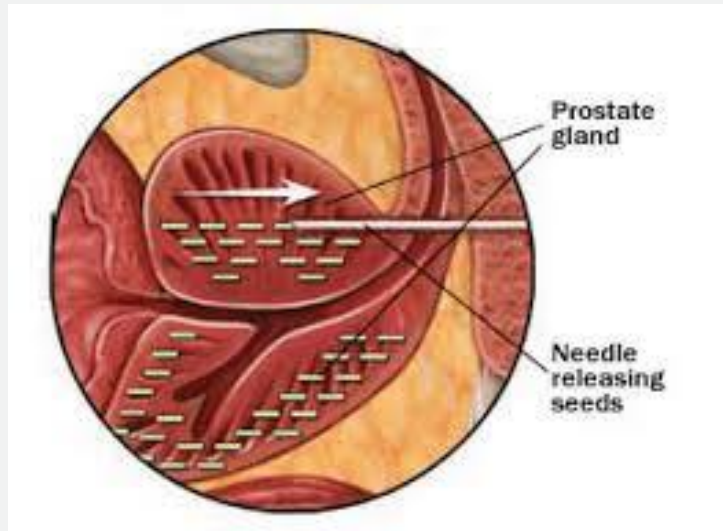
# Included Cancer Types

Cancer Type	ICD-10 Codes
Anal Cancer	C21.xx
Bladder Cancer	C67.xx
Bone Metastases	C79.51
Brain Metastases	C79.3x
Breast Cancer	C50.xx, D05.xx
Cervical Cancer	C53.xx
CNS Tumors	C70.xx, C71.xx, C72.xx
Colorectal Cancer	C18.xx, C19.xx, C20.xx
Head and Neck Cancer	C00.xx-C14.xx, C30.xx-C32.xx, C76.0x

# Included Cancer Types

Cancer Type	ICD-10 Codes
Lung Cancer	C33.xx, C34.xx, C39.xx, C45.xx
Lymphoma	C81.xx-C86.xx, C88.xx, C91.4x
Pancreatic Cancer	C25.xx
Prostate Cancer	C61.xx
Upper GI Cancer	C15.xx-C17.xx
Uterine Cancer	C54.xx, C55.xx

# Included Therapies



- 3-dimensional conformal radiotherapy (CDCRT)
- Intensity-modulated radiotherapy (IMRT)
- Stereotactic radiosurgery (SRS)
- Stereotactic body radiotherapy (SBRT)
- Proton beam therapy (PBT)
- Image-guided radiation therapy (IGRT)

# More Information



- Vitalware hosted a webinar on 12/8/21 to cover the key elements of the RO model
- More information can be found at <https://innovation.cms.gov/innovation-models/radiation-oncology-model>



# Questions?

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# Thank you!