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Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Proposed Rule

OVERVIEW

On July 1st, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule for the Calendar Year (CY) 2016 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System. The proposed rule updates Medicare payment policies and rates for hospital outpatient departments, ASCs, and partial hospitalization services furnished by community mental health providers. The proposed rule also includes modifications to the two-midnight rule.

CMS will accept comments on the proposed rule until August 31st. This document summarizes several major provisions of the proposed rule. The full text of the proposed rule is available here.

OPPS PAYMENT UPDATE

CMS proposes to reduce OPPS rates by 0.1 percent. This change is the net effect of a 2.7 percent market basket increase, a 0.6 percentage point decrease in the multifactor productivity adjustment, a required 0.2 percentage point decrease, and an additional one-time 2.0 percentage point decrease to offset inflation in the OPPS payment rates resulting from excess packaged laboratory test payments paid separately outside of the OPPS.

TWO-MIDNIGHT RULE

CMS is proposing to modify the two-midnight rule, which is the Agency's benchmark for determining which hospitalizations should be considered inpatient stays payable under Medicare Part A.

CMS maintains the current standard that hospitalizations expected to last less than two midnights should be billed as outpatient stays except in rare and unusual circumstances, but expands the exceptions process to include a case-by-case review based on the clinical judgment of the admitting physician. Documentation in the medical record must support the necessity of an inpatient admission and would be reviewed by CMS Quality Improvement Organizations (QIOs). CMS does not propose to change the policy for stays over the two-midnight benchmark, reverse the 0.2 percent payment cut associated with the two-midnight policy, or extend the moratorium on RAC review.

CHRONIC CARE MANAGEMENT SERVICES

In CY 2015, CMS adopted payment code 99490 for Chronic Care Management (CCM) services, which covers non face-to-face care management and coordination for Medicare beneficiaries who have two or more chronic conditions expected to last at least 12 months or until the death of the patient. Under the proposed rule, CMS is proposing additional requirements for hospital outpatient departments to bill and receive payment for CPT code 99490 for CY 2016 and subsequent years.

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The proposed requirements include:

- Permitting hospital outpatient departments to bill the CCM code only when a patient has been admitted to the hospital as an inpatient or registered outpatient of the hospital and received services within the last 12 months. This clarification is proposed to ensure that the hospital has a prior relationship with the patient as a requirement for billing and OPPS payment; and
- Only one hospital can provide and be paid for services described by CPT code 99490 during the calendar month service period.

COMPREHENSIVE AMBULATORY PAYMENT CLASSIFICATIONS (C-APCS) FOR COMPREHENSIVE OBSERVATION SERVICES

A C-APCS is an ambulatory payment classification that provides for an encounter-level payment for a designated primary procedure and usually, all adjunctive and secondary services provided in conjunction with the primary procedure. For CY 2016, CMS proposes adding nine new C-APCs, including a new C-APC for comprehensive observation services. CMS proposes that the new C-APC for observation services would provide comprehensive payment for all services received when receiving comprehensive observation. Comprehensive observation is defined as a non-surgical encounter with a high-level outpatient hospital visit and eight hours or more of observation.

QUALITY REPORTING PROGRAM CHANGES

Outpatient hospital departments are currently subject to a 2.0 percentage point payment reduction for failure to meet the requirements of the Hospital Outpatient Quality Reporting (OQR) program. CMS proposes to add two National Quality Forum (NQF) supported measures to the OQR:

- For the CY 2018 payment determination: External Beam Radiotherapy for Bone Metastases (NQF:#1822): Percentage of patients with painful bone metastases and no history of previous radiation who receive EBRT with an acceptable dosing schedule; and
- For CY 2019 payment determination: Emergency Department Transfer Communication (EDTC) Measure (NQF: #0291): Percentage of patients transferred to another healthcare facility whose medical record documentation indicated that administrative and clinical information was communicated to the receiving facility in an appropriate time frame.

CMS proposes to remove one measure from the OQR program: Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache, as it no longer aligns with the most up to date guidelines for clinical practice.