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

OVERVIEW

On October 30th, the Centers for Medicare and Medicaid Services (CMS) issued a final rule for the Calendar Year (CY) 2016 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System. The final rule updates Medicare payment policies and rates for hospital outpatient departments, ASCs, and partial hospitalization services furnished by community mental health providers. The final rule also includes modifications to the two-midnight rule.

This document summarizes several major provisions of the final rule. The full text of the final rule is available here.

OPPS PAYMENT UPDATE

In the final rule, CMS is reducing the payment rate under the OPPS by 0.3 percent. This reduction is the net effect of a 2.4 percent market basket increase, a 0.5 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.

This is a larger reduction than the 0.1 percent decrease in the proposed rule.

TWO-MIDNIGHT RULE

CMS finalized its proposal 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 policy 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 be reviewed by CMS Quality Improvement Organizations (QIOs). The final rule does not 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 death.

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CMS finalized its proposal to permit 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. Only one hospital can bill the CCM code for a given patient during the calendar month service period.

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

A C-APC is an ambulatory payment classification that provides for an encounter-level payment for a designated primary procedure and secondary services provided in conjunction with the primary procedure. For CY 2016, CMS is finalizing its proposal to add nine new C-APCs, including a new C-APC for comprehensive observation services.

CMS proposed that the new C-APC for observation services would provide comprehensive payment for all services provided 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. CMS is finalizing the C-APC for comprehensive observation services, but will exclude all surgical procedures from being bundled into the observation C-APC, regardless of date of service.

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 is finalizing the addition of one National Quality Forum (NQF) supported measure 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.

CMS proposed adding Emergency Department Transfer Communication (NQF: #0291) but is not finalizing the addition of this measure for CY 2019 or subsequent years.