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2019 Hospital Outpatient and Ambulatory Surgical Center Final Rule

OVERVIEW

On November 2nd, the Centers for Medicare and Medicaid Services (CMS) finalized a rule that will update the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Centers (ASCs) Payment System for 2019. The rule will increase OPPS rates by 1.35% and ASC payment rates by 2.1%.

In addition to finalizing a number of payment and policy changes, the rule includes a comment period for proposed changes to the Partial Hospitalization Program Ambulatory Payment Classifications (PHP APC) code set. CMS would remove six existing codes for the PHP-allowable code set for Community Mental Health Center APC 5853 and hospital-based PHP APC 5863, and replace them with nine new codes in 2019. These changes were outlined in the 2019 Hospital OPPS proposed rule, but CMS did not include them in the PHP section and is requesting comment again to ensure that PHP providers see the proposed change. CMS will accept comments until December 3rd.

The final rule is available here.

Off-Campus Provider-Based Department (PBD) Payments

Under the final rule, clinic visit services rendered at off-campus PBDs will receive a Physician Fee Schedule (PFS)-equivalent payment rate, rather than an OPPS rate. The proposed rule would have also paid for new services delivered by excepted off-campus PBDs above a certain threshold under the PFS, rather than the OPPS. CMS did not finalize this proposal, but will continue to monitor the expansion of services in excepted off-campus PBDs.

ASC Covered Procedure List (CPL)

The rule will expand the list of covered surgical procedures that are payable at an ASC. Currently, the ASC CPL includes covered surgical procedures described by certain Common Procedural Terminology (CPT) codes that are *within* the surgical code range or other types of codes that are similar to CPT codes within the surgical code range. The final rule will allow certain new CPT codes *outside* the surgical code range to also be included on the ASC CPL.

Drug Payment Cuts

The 2018 OPPS final rule decreased payment rates for most hospitals purchasing certain covered outpatient drugs through the 340B Drug Pricing Program from the Average Sales Price (ASP) plus 6% to ASP minus 22.5%. The 2019 rule will expand the 340B payment cut to non-excepted off-campus PBDs paid under the PFS. Rural sole community hospitals, children's hospitals, and PPS-exempt cancer hospitals will still be exempt from 340B cuts.

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The rule will also pay for separately payable drugs and biological products that do not have pass-through payment status and are not acquired under the 340B Program at wholesale acquisition cost (WAC) plus 3% instead of WAC plus 6%, if Average Sales Price (ASP) Data is not available.

Opioid Provisions

To encourage the use of non-opioid pain management drugs, the rule will pay ASP plus 6% for non-opioid pain management drugs prescribed for covered surgical procedures performed in an ASC. The rule will also remove several pain communication questions from the Hospital Inpatient QRP in an effort to avoid opioid overprescribing.

New Technology Ambulatory Payment Classifications (APCs)

Under the final rule, services assigned to New Technology APCs with fewer than 100 claims per year will be excluded from bundling into Comprehensive APCs in order to gather more accurate data. Such services will be paid under an alternative payment methodology that uses up to four years of data to calculate the geometric mean, median, and arithmetic mean.

ASC-Covered Device-Intensive Procedures

Currently, CMS defines device-intensive procedures as those in which the device cost exceeds 40% of the total cost of the procedure. To allow a greater number of ASC procedures to qualify as device-intensive, the final rule will lower the threshold to 30% of the cost of the procedure. The rule will also require that the device be implanted or inserted and allow procedures that involve single-use devices to qualify as device-intensive, regardless of whether or not they remain in the body after the conclusion of the procedure.

Quality Reporting Programs (QRPs)

Under the Hospital Outpatient Quality Reporting (OQR) Program and ASC Quality Reporting (ASCQR) Program, outpatient hospital departments and ASCs receive a 2% payment reduction or failure to meet certain requirements. The final rule will remove the following measures from the Hospital OQR:

- Median Time to ECG;
- Mammography Follow-up Rates;
- Thorax Computed Tomography Use of Contrast Material;
- Simultaneous Use of Brain Computed Tomography;
- Web-based Tool Measures;
- The Ability for Providers with HIT to Receive Their Qualified/Certified EHR System as Discrete Searchable Data;
- Tracking Clinical Results Between Visits;

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- Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps-Avoidance of Inappropriate Use; and
- Influenza Vaccination Coverage Among Healthcare Personnel.

The following measures will be removed from the ASCQR Program:

- Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps-Avoidance of Inappropriate Use; and
- Influenza Vaccination Coverage Among Healthcare Personnel.