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The 2020 OPPS Final Rule: Key Takeaways for Healthcare Organizations

December 17, 2019

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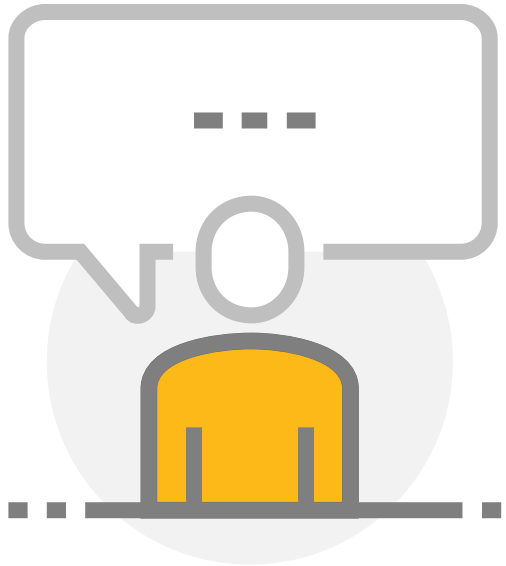

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Today's Speakers

Carol Bates

Carol is a Senior Advisor within Crowe's Healthcare Performance practice. She has extensive experience in revenue integrity, charge capture, CDM and laboratory management. Carol is a certified coder and medical technologist.

Caroline Meyer

Caroline is a Staff Advisor within Crowe's Healthcare Performance practice. She has a background in healthcare management and focuses on clinical revenue management and charge capture.

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Key Discussion Points For Today

- Payment Rates
- Inpatient Only Procedures
- Two-Midnight Rule
- Device Pass-Through Payment Applications
- Substantial Clinical Improvement Criterion
- Ambulatory Surgical Center Quality Report (ASCQR) Program
- Organ Procurement
- Outpatient Level of Supervision
- Therapeutic Services in Hospitals and Critical Access Hospitals
- Rural Adjustments
- Cancer Hospital Payment Adjustment
- Conversion Factor
- Comprehensive-APC
- Site-Neutral Payment Rule Adjustments
- Prior Authorization Process and Requirements
- ASC Covered Surgical Procedures
- Price Transparency
- 340B Drug Payment Policy
- Comprehensive Code Change Update (CPT Updates)

Major Provisions for CY 2020: What You Need to Know

Payment Rates Update

- CMS estimates that OPPS expenditures for 2020 will be $79.0 billion
  - This is an increase of approximately $6.3 billion compared to 2019 OPPS payments

- For CY 2020, CMS estimates that conversion factor and adjustment updates will result in an increase of payment rates under the OPPS for services provided by an Outpatient Department by **1.3%**
  - The following factors were considered when calculating the payment rate increase:
    - 3.0% increase due to inpatient market basket update
    - 0.4% decrease due to the ACA's required multifactor productivity adjustment

- CMS will continue to implement the statutory 2.0% reduction in payments for hospitals failing to meet the hospital outpatient reporting requirements
  - A 0.981 reporting factor will be applied to the OPPS payments and copayments for all applicable services

Inpatient Only Procedures

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

- CMS also reviews procedures to be added to the inpatient only list with the following criteria:
  - The nature of the procedure;
  - The underlying physical condition of the patient; or
  - The need for at least twenty-four hours of postoperative recovery time for monitoring before the patient can be safely discharged

Inpatient Only Procedures

For CY 2020 CMS has removed twelve procedures from the inpatient only list (IPO)

Removed:

- Orthopedics
  - CPT 27130: Total Hip Arthroplasty

- Spinal procedures
  - CPT 22633 & 22634: Arthrodesis, combined posterior or posterolateral technique; lumbar
  - CPT 63265-63268: Laminectomy for excision of AV malformation or intraspinal lesion other than neoplasm

- Anesthesia procedures
  - Five procedures are proposed

Two-Midnight Rule (Short Inpatient Hospital Stays)

- For CY 2020, CMS will enforce a two-year exemption period from Beneficiary and Family-Centered Care Quality Improvement Organizations (BFCC-QIOs) referrals to Recovery Audit Contractors (RACs)

- Procedures on the Inpatient Only List (IPO) under the OPPS do not qualify for two-midnight rule payments; however, once they are removed from the IPO list, that changes
  - If removed from the IPO list and subsequently billed out, these procedures may be vulnerable to medical reviews or audits conducted by Beneficiary and Family-Centered Care Quality Improvement Organizations
  - Additional payment policy compliance issues may be assessed by Recovery Audit Contractors

- What does this exemption period mean for your organization?
  - For the duration of the exemption period, your organization will not be at risk for reviews or audits should you bill for procedures previously listed on the IPO list

Device Pass-Through Payments and Criterion

- For CY 2020, CMS has approved four applications for device pass-through payment status
  - A fifth application will also be approved after received a Breakthrough Devices designation from the Food and Drug Administration
    - This application was not discussed in the CY 2020 OPPS/ASC proposed rule
    - This application qualifies for the alternative pathway

- Additionally, CMS is developing an alternative pathway to the substantial clinical improvement criterion for devices approved under the FDA Breakthrough Devices Program
  - This effort will allow these devices to qualify for device pass-through status

Ambulatory Surgical Center Quality Report (ASCQR)

- CMS is adding one new measure, ASC-19: Facility-Level 7-Day Hospital Visits after General Surgery Procedures Performed at Ambulatory Surgical Centers
  - This will begin with the CY 2024 payment determination.

- CMS examined data surrounding unplanned, post-surgical hospital visits associated with patients receiving care at Ambulatory Surgical Centers.
  - High rates of these visits indicated potential quality of care issues.
  - Thus, this will create a new metric to monitor outcomes and care.

Polling Question #1

Polling Question #1

For CY 2020, CMS is increasing the payment rates under the OPPS for services provided by an Outpatient Department by

A) 1.1%
B) 1.3%
C) 1.5%
D) 1.7%

Organ Procurement Updates

- For CY 2020, CMS is updating the definition of “expected donation rate” to match the Scientific Registry of Transplant Recipients

- As a temporary change, the need for OPOs to meet two out of three outcome measures for the 2022 recertification cycle does not apply
  - This will help some OPOs which might have otherwise become decertified in 2022
  - Please note that this change is temporary, and the requirement will be reinforced in future

- CMS solicited public comments on various related measures

Supervision of Outpatient Therapeutic Services

- For CY 2020, the minimum required level of supervision for all hospital outpatient therapeutic services provided incident to a physician at hospitals and at CAHs has been changed from direct supervision to **general supervision**

- Why make this change?
  - Historically, CAHs and small, rural hospitals have expressed concerns with CMS's policy of requiring direct supervision for outpatient therapeutic services
  - Thus, CMS has enforced direct supervision at most facilities, but allowed Medicare providers to provide general supervision for most outpatient therapeutic services at CAHs and rural hospitals
  - Given the lack of issues at these hospitals, CMS has determined that reducing the policy to general supervision for most outpatient therapeutic procedures at all facilities will be beneficial to all providers

Rural Adjustment

- Continuation of the adjustment rate of 7.1% to the OPPS payments to certain Rural Sole Community Hospitals (SCHs) and Essential Access Community Hospitals (EACHs)

- Applies to all services paid under the OPPS
  - Exceptions include:
    - Separately payable drugs, biologicals, brachytherapy sources
    - Devices paid under the “Pass-through Payment” policy
    - Items paid at charge reduced to cost

- This will not have any significant impact on hospitals given that it is not representative of any policy change

Cancer Hospital Payment Adjustment

- CMS will continue to provide additional payments to Cancer Hospitals so that the Cancer Hospital's payment-to-cost ratio (PCR) after the additional payments is equal to the weighted average PCR for the other OPPS hospitals

- CMS has finalized a target PCR of **0.89** to determine the CY 2020 Cancer Hospital payment adjustment

- This will not have any significant impact on hospitals given that it is not representative of any policy change

Conversion Factor Update

- For CY 2020, CMS calculates an OPPS conversion factor of $80.784 for those items and services for which payment rates are calculated using geometric mean costs

- 2019 conversion factor of $78.636 was adjusted by the fee schedule increase factor and various budget neutrality factors

- In addition, the final rule indicates that the following adjustments are applied in calculating the 2020 conversion factor:
  - Proposed OPD fee schedule increase factor of 2.6 percent
  - Wage index budget neutrality factor of 0.9981
  - Adjustment for pass-through spending of 0.88 percent

Comprehensive Ambulatory Payment Classification (C-APC)

- For CY 2020, CMS is adding two C-APCs (sixty-seven total)
  - C-APC 5182 (Level 2 Vascular Procedures)
  - C-APC 5461 (Level 1 Neurostimulator and Related Procedures)

- These additional C-APCs would be effective in CY 2020

- Reporting of items/services should not change – all items/services performed should still be charged

Polling Question #2

Polling Question #2

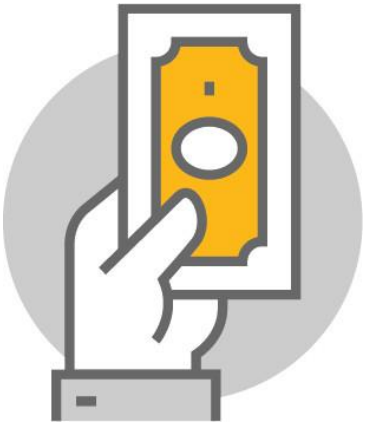
True or False: As of CY 2020, CMS will have implemented a total of sixty-five Comprehensive APCs; an increase of three C-APCs from 2019

A) True
B) False

Key Takeaways That May Impact Your Organization

Site-Neutral Payment for E&M Services

- In 2019, CMS implemented a 30% reduction factor for E&M services described by HCPCS code G0463 when provided at excepted off-campus hospital outpatient department (HOPD)
  - This was half the payment differential under two year phase-in policy to implement site-neutral payment
- CMS acknowledges the district court vacated the volume control policy for 2019 and is ensuring the affected 2019 claims are paid consistent with the court's order
  - For 2020, CMS will implement the full 60% reduction
  - The government is currently deciding whether to appeal the final judgment
- CMS estimates $800 million in savings for CY 2020
  - $640 million to Medicare
  - $160 million to Medicare Beneficiaries



What Can Your Organization Do to Prepare?

- **Understand which facilities and services are impacted**
  - The updated rate applies to clinic visit code only (G0463) when provided at an “excepted” off-campus PBD (departments that bill the modifier “PO” on claim lines)

- **Prepare to adapt to the changing landscape**
  - With a reduction in reimbursement rates, health systems will need to focus on maximizing cost-efficiency within provider-based off-campus departments
    - Lease agreements
    - Services provided

  - Health Systems are becoming more creative with their approach to outpatient facilities
    - Increase in “micro-hospitals” and free-standing EDs
    - Expanding hospital campuses
    - Streamlining referral networks

Prior Authorization for Certain OPD Services

- Beginning in CY 2020, CMS will require hospitals to meet a prior authorization request for any service on its list of outpatient department services requiring prior authorization

- 5 Categories of Service
  1. Blepharoplasty
  2. Botulinum Toxin Injections
  3. Panniculectomy
  4. Rhinoplasty
  5. Vein Ablation

  - There is not a prior authorization requirement for these services when they are provided in an ASC

What Can Your Organization Do to Prepare?

- **Understand which facilities and services are impacted**
  - ASCs are excluded from this requirement
  - The 5 Categories of Service Affected:
    1. Blepharoplasty
    2. Botulinum Toxin Injections
    3. Panniculectomy
    4. Rhinoplasty
    5. Vein Ablation

- **Implement necessary workflow measures to ensure prior authorization requests are met**
  - Reimbursement for these services is contingent on this prior authorization, so internal measures must be taken to ensure proper payment

Polling Question #3

Polling Question #3

Beginning in CY 2020, which category of service will require prior authorization when provided at an ASC?

A) Blepharoplasty
B) Vein Ablation
C) Panniculectomy
D) None of the above

Additions to the ASC Surgical Covered Procedures List

In 2020, CMS adds the following items to the ASC Surgical Covered Procedures List:

1. Total knee replacement (TKA)
2. Mosaicplasty procedure
3. Six coronary intervention procedures
4. Twelve procedures with new CPT codes to the list of surgical procedures covered when performed in ASC

Additions to the ASC Surgical Covered Procedures List

CY 20 CPT Code	CY 20 Long Descriptor	CY 20 ASC Payment Indicator
15769	Grafting of autologous soft tissue, other, harvested by direct excision (e.g., fat, dermis, fascia)	G2
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate	G2
15773	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less injectate	G2
27447	Arthroplasty, knee, condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty)	J8
29867	Arthroscopy, knee, surgical; osteochondral allograft (e.g., mosaicplasty)	J8
33016	Pericardiocentesis, including imaging guidance, when performed	G2
46948	Hemorrhoidectomy, internal, by transanal hemorrhoidal dearterialization, 2 or more hemorrhoid columns/groups, including ultrasound guidance, with mucopexy, when performed	G2
62328	Spinal puncture, lumbar, diagnostic; with fluoroscopic or CT guidance	G2
62329	Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter); with fluoroscopic or CT guidance	G2
64451	Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (i.e., fluoroscopy or computed tomography)	G2

Additions to the ASC Surgical Covered Procedures List

CY 20 CPT Code	CY 20 Long Descriptor	CY 20 ASC Payment Indicator
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (i.e., fluoroscopy or computed tomography)	G2
66987	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1- stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with endoscopic cyclophotocoagulation	J8
66988	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1- stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification); with endoscopic cyclophotocoagulation	J8
92920	Percutaneous transluminal coronary angioplasty; single major coronary artery or branch	G2
92921	Percutaneous transluminal coronary angioplasty; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)	N1
92928	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	J8

Additions to the ASC Surgical Covered Procedures List

CY 20 CPT Code	CY 20 Long Descriptor	CY 20 ASC Payment Indicator
92929	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)	N1
0587T	Percutaneous implantation or replacement of integrated single device neurostimulation system including electrode array and receiver or pulse generator, including analysis, programming, and imaging guidance when performed, posterior tibial nerve	J8
C9600	Percutaneous transcatheter placement of drug eluting intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or Branch	J8
C9601	Percutaneous transcatheter placement of drug-eluting intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)	N1

What Can Your Organization Do to Prepare?

- **Educate coding and billing staff**
  - Ensure that coding and billing staff are aware and prepared for these updates

- **Educate clinical teams**
  - Organizations should team CDM and Revenue Integrity representatives with Clinical Informatics/Educators to relay education components and optimize current EMR to support required documentation improvement initiatives

- **Prepare for the future**
  - Develop monitoring tools and an accountability pathway to ensure adherence to newly implemented documentation and coding requirements
  - Promote internal transparency by communicating the results amongst leadership teams

Looking Ahead… Price Transparency

- These requirements have been created in a separate rule and will be finalized at a later date
- CMS expands its prior interpretations of Section 2718 of the Public Health Service Act
- The proposed rule would require all hospitals to make a list of gross charges and negotiated rates for all services in the hospital CDM and a set of shoppable services publicly available
- This rule will specify the manner and format in which the lists are to be made publicly available
- Hospitals that do not comply with the requirement may be subject to a civil monetary penalty of up to $300 per day

What Can Your Organization Do to Prepare?

- **Organize and evaluate payer contracts and rate sheets**
  - This will be instrumental when validating charges
- **Create price estimation models for patients**
  - Aids patients in efficiently making decisions regarding care
- **Develop a workflow to establish proper communication from front to back end of revenue cycle**
  - Employees must be educated on price transparency and have the support of departments throughout the revenue cycle to ensure accurate estimates to consumers

Updates to 340B Drug Payment Program

- For CY 2020, CMS will continue to pay ASP minus 22.5% for 340B-acquired drugs including when furnished in nonexcepted off-campus PBDs paid under the PFS

- In light of ongoing litigation, CMS summarized comments received on a potential remedy for 2018 and 2019. It intends to conduct a 340B hospital survey to collect drug acquisition cost data for CY 2018 & 2019. Survey data may be used in setting the Medicare payment amount for drugs acquired by 340B hospitals for cost years going forward, and may also be used to devise a remedy for prior years in the event of an adverse decision on appeal

- In the event 340B hospital survey data are not used to devise a remedy, consideration of suggestions from commenters submitted in response to the comment solicitation may be used to propose a remedy in CY 2021 OPPS/ASC proposed rule

What Can Your Organization Do To Prepare?

- **Understand exception status**
  - For CY 2020 Critical access hospitals, rural sole community hospitals, children's hospitals, and PPS-exempt cancer hospitals continue to be excepted from the 340B payment rates

- **Ensure that necessary measures are in place beginning January 1, 2020**
  - Health systems need to ensure that proper billing edits are established, and education is provided to billing and coding staff regarding the facility's 340B status and which drugs/biologicals qualify for all PBDs

- **Continue to utilize the two modifiers to be used with drugs or biologicals acquired under 340B**
  - "JG" – Used to trigger payment adjustment for all providers that ***are not*** excepted from the 340B Drug Payment Policy
  - "TB" – Used for information purposes only by providers that ***are*** excepted from the 340B Drug Payment Policy (rural SCH, children's hospitals, and PPS-exempt cancer hospitals)

Comprehensive Code Changes

2020 CPT Code Changes – Overview

For 2020 there are a total of 394 code changes. The below table summarizes the 2020 CPT code annual updates by CPT category

Categories	New Codes	Deleted Codes	Revised Codes	Total
Evaluation & Management (99201-99484)	6	1	1	8
Anesthesia (00100-01999)	0	0	0	0
Surgery (10004-69999)	38	17	37	92
Radiology (70010-79999)	12	15	18	45
Pathology & Laboratory (80047-89389)	14	0	4	18
PLA (0001U-0138U)	75	5	1	81
Medicine (90281-99199), (99500-99607)	47	21	10	78
Category II (0001F-9007F)	5	1	3	9
Category III (0042T-0593T)	51	11	1	63
Total	248	71	75	394

Updates to Evaluation and Management (E&M) Codes

- The E&M section has six additions, one deletion and one revision

- New codes have been added to report online digital evaluation services, or e-visits. These codes describe patient-initiated communications provided by physician or other qualified health care professional (99421, 99422, 99423) or a non-physician health care professional (98970, 98971, 98972)

- Two codes were added to better support home blood pressure monitoring. CPT codes 99473 and 99474 report self-measured blood pressure monitoring

Updates to Surgery - Musculoskeletal

- The Surgery section has thirty-eight additions, seventeen deletions and thirty-two revisions. Most of the changes in surgery lie within the Musculoskeletal and Cardiovascular subsections

- Six (6) new add-on codes have been added (20700-20705) for manual preparation & insertion and removal of drug-delivery devices
  - Mixing & preparation of antibiotics or other therapeutic agent(s) with a carrier substance
  - Shaping the substance into a drug-delivery device (eg, beads, nails, spacers)
  - Placement in deep, intramedullary or intra-articular space(s)
  - Removal of drug-delivery device(s)

- Three codes (21601-21603) were added to more accurately describe excision of chest wall tumors
  - Excision of chest wall tumor including rib(s)
  - Excision of chest wall tumor involving rib(s), with plastic reconstruction; without mediastinal lymphadenectomy
  - Excision of chest wall tumor involving rib(s), with plastic reconstruction; with mediastinal lymphadenectomy

Updates to Surgery - Cardiovascular

- Four new codes (33016-33019) have been added to report pericardiocentesis and pericardial drainage with insertion of an indwelling catheter
  - Imaging guidance is included with the new codes
  - Radiology supervision and interpretation code 76930 has been deleted

- Two new codes (33858-33859) were created to specify the purpose of an ascending aortic graft. These differentiate if the procedure was performed for aortic dissection or for aortic disease other than dissection

- Temporary code 0254T (iliac artery endovascular repair using an endograft) is being deleted and replaced by two permanent codes (34717-34718)
  - Code 34717 will be an add-on code reported if the repair is performed during the same operative session as an aorto-iliac artery endograft placement
  - Code 34718 will be reported when the endovascular repair of the iliac artery is performed independent of an aorto-iliac artery endograft

Updates to Radiology – Nuclear Medicine

- There was a reduction in the amount of total codes from six in 2019 to one in 2020 for site specific single photon emission computed tomography (SPECT). Established code 78803 specifies tomographic SPECT for a single area and single day imaging

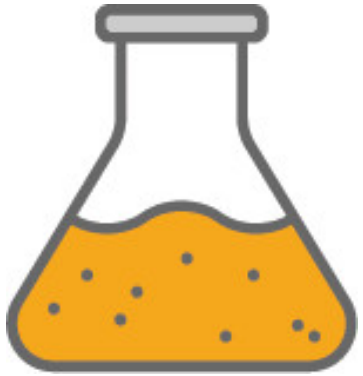
- Three codes for radiopharmaceutical localization of the inflammatory process (78805-78807) are being replaced by eleven possible codes allowing for more specificity (78300, 78305, 78306, 78315, 78800, 78801, 78802, 78803, 78830, 78831, 78832)

- Five new codes for myocardial imaging positron emission tomography (PET) have been added (78429-78433)

- One new add-on code 78434 was created describing “Absolute quantitation of myocardial blood flow (AQMBF), positron emission tomography (PET), rest and pharmacologic stress”

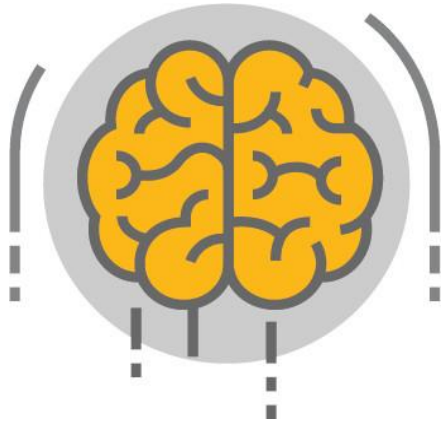
Updates to Laboratory

- There are fourteen additional codes and one revised code for Laboratory
- Six new codes have been added for therapeutic drug assays
- Four new Tier 1 Molecular Pathology codes have been added
- Three new Multianalyte Assays with Algorithmic Analyses (MAAAs) have been added
- One Microbiology procedure has been added



Updates to Medicine - Neurology

- The biggest impact can be found on long-term electroencephalograms (EEG's), EEG monitoring and EEG with video (VEEG)
- Four codes with described EEG monitoring were deleted and replaced by twenty-three new codes (95700-95726)
- Codes in this section are divided into two groups
  - Technical services
  - Professional services
- Refer to AMA Long-Term EEG Monitoring Table



Updates to Medicine – Health Behavior Assessment & Intervention

- Nine new codes replace six deleted codes
- New codes more accurately reflect current practice
  - Interdisciplinary care coordination
  - Teamwork with physicians in primary care and specialty settings
- Intervention codes are time-based
- Code definitions determine individual or group intervention

What Can Your Organization Do To Prepare?

- **Below are suggested steps in preparing and implementing the CY2020 OPPS coding changes**

Analysis of the CDM
Analyze the current CDM to understand the CPT/HCPCS coding, charge structure and pricing revisions that need to be implemented.

Updating of the charge capture systems
Inventory the specific charge capture sub-systems that need to be updated as part of the process.

Department education
Education of the required department staff on all applicable changes to the charge master and charge capture systems.

Verification analysis
Once all changes to the CDM and charge capture systems are implemented, conduct an analysis to verify accuracy and completeness.

Polling Question #4

Polling Question #4

True or False: There are a total of 400 code changes effective January 1st 2020

A) True
B) False

Questions?

This presentation will be sent out with the presenters' contact information

Please feel free to reach out to any of us with any questions or for any additional information regarding the 2020 OPPS Final Rule

Any questions submitted during the webinar will be responded to via email as promptly as possible

Thank you!

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