Calendar Year 2016 OPPS Rule Update

By Crystal Clack, MS, RHIA, CCS

On October 30, 2015, the Centers for Medicare and Medicaid Services (CMS) finalized changes to the Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center (ASC) payment system for calendar year (CY) 2016. The OPPS payment rates and policies impact approximately 4,000 hospitals and 60 community mental health centers. The ASC payment system impacts approximately 5,300 ASC centers across the United States.

While every attempt is made to highlight the major OPPS Rule changes for CY 2016 in this article, there are many details and formulas not discussed. The author recommends thoroughly reviewing CY 2016 specialty-specific changes on the CMS website. This article highlights payment and policy updates for 2016.

Hospital and Ambulatory Services

Due to CY 2016 CMS updates in the conversion factor by -0.3 percent, hospital outpatient services anticipate a decrease in payments from $74.144 in CY 2015 to $73.929 in CY 2016. This roughly averages out to $130 million in 2016. For ASCs, however, CMS will increase payments by 0.3 percent.

OPPS Expenditures for Laboratory

In CY 2016, CMS has changed billing methodology on laboratory test packaging by implementing a conditional packaging status indicator of "Q4" for clinical diagnostic laboratory tests. Under this change, hospitals should see a decrease in potential denials and reimbursement issues when a patient does not undergo other outpatient services on the same day as laboratory services. The policy for laboratory test packaging is also updated to reflect a new packaging status indicator for specific lab tests.

Chronic Care Management (CCM) Clarification

Providers had many questions in CY 2015 regarding the new CCM service updates. CCM services are non-face-to-face care management for Medicare beneficiaries who have two or more multiple, significant, chronic conditions. These updates included separate payment codes for CCM services in a hospital outpatient setting. Beginning in 2016 hospitals that provided therapeutic services to an inpatient or outpatient within the last 12 months may bill CPT code 99490 for any CCM services.

Ambulatory Payment Classifications (APCs)

As required by law, the yearly review of relative payment weights was performed by CMS on all OPPS clinical APCs, resulting in the restructuring and elimination of unnecessary APCs in nine APC surgical and diagnostic procedure categories. The following clinical categories are impacted:

- Diagnostic tests and related services
- Endoscopy procedures
- Gastrointestinal procedures
- Imaging services to include diagnostic radiology and nuclear medicine
- Incision and drainage as well as excision and biopsy procedures
- Orthopedic procedures
- Skin related procedures
- Urology

- Vascular

The details of these changes should be reviewed in the full update on CMS' website, according to specialty, to determine the full financial impact on outpatient services.

Comprehensive Ambulatory Payment Classifications (C-APCs)

CMS defines a C-APC as a "classification for the provision of a primary service and all adjunctive services provided to support the delivery of the primary service."[1] In CY 2015, C-APCs were established by CMS to provide preset payments for specified procedures, and any additional healthcare services delivered in conjunction with the principal procedure. There are currently 25 C-APCs, including implanted medical devices and the procedure associated with the implant. In CY 2016, nine new C-APCs are introduced which include C-APCs for comprehensive observation services.

The high-level observation services addressed by CMS are, by definition, "…delivered during a non-surgical outpatient encounter with > 8 hours observation." These services are reimbursed by the Comprehensive Observation C-APC payment bundle. It is important to note this applies only to non-surgical observation services. For example, if a surgical procedure code appears on a "Comprehensive Observation" patient's claim, the payment will be paid based on the surgical APC and not on the Comprehensive Observation C-APC.

In CY 2016, CMS packages a handful of ancillary services specific to minor procedures and pathology services. Drugs considered integral to surgical supplies are now packaged with the surgical procedure. Ancillary services are paid separately to the ASC on items and services specific to approved surgical procedures. Updates include exclusions of the following services from the C-APC payment policy, based on the "Comprehensive APC Payment Policy Exclusions for CY 2016" table in the *Federal Register*:[2]

- Ambulance services
- Brachytherapy
- Diagnostic and mammography screenings
- Physical therapy, speech-language pathology, and occupational therapy services
- Certain Part B inpatient services
- Preventative services as defined in 42 CFR 410.2, such as:
    - Annual wellness visits with personalized prevention plan services
    - Initial preventive physical examinations
    - Pneumococcal, influenza, and hepatitis B vaccines and administrations
    - Pap smears and pelvic exams
    - Prostate cancer screening tests
    - Colorectal cancer screening tests

For the comprehensive list, refer to www.cms.gov.

Packaged Services, ASC Covered Ancillary Services, and Partial Hospitalization

A Partial Hospitalization Program (PHP) is an intensive psychiatric outpatient program that provides treatment to patients discharged from an inpatient psychiatric facility. The patients benefit from further psychiatric treatment as necessitated per their provider's orders. In CY 2016, CMS is focusing on PHP settings in an effort to control irregular costs commonly associated with the treatments. Furthermore, by being able to control costs, CMS is equipped to deliver greater rate transparency with rates to PHP providers.

Quality Reporting Program Changes

CMS is adding two new measures to the Hospital Outpatient Quality Reporting Program:

- External Beam Radiotherapy for Bone Metastases (NQF#1882)
- Emergency Department Transfer Communication (EDTC) Measure (NQF#0291)

CMS is also removing one measure, OP-15: Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache. Policy changes are being proposed by CMS to coincide with the Ambulatory Surgical Center Quality Reporting Program (ASCQR):

- Change withdraw deadline from November 1 to August 31
- Change the specific quarters payment determinations
- Change timeframe for data submission measures submitted via CMS from July 1 – November 1 to January 1 – May 15
- Change deadline for submitting a reconsideration request from the first business day of the month of February of the affected payment year to the first business day on or after March 17 of the affected payment year
- Paragraphs 42 CFR 419.46 (f)(1) and 42 CFR 419.46 (e)(2) are to replace the term "fiscal year" with the term "calendar year"

Lastly, the Ambulatory Surgical Center Quality Reporting (ASCQR) Program requirements must be met by ASCs in CY 2018, or they will be subjected to a 2.0 percentage point reduction in their annual payment updates. The ASCQR program measure set includes 12 measures, with 11 required and one voluntary. CMS excludes Indian Health Service hospital outpatient departments from the ASCQR program because of their requirement to meet conditions of participation for hospitals and not conditions of coverage for ASCs.

Notes

[1] Centers for Medicare and Medicaid Services. "Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Short Inpatient Hospital Stays; Transition for Certain Medicare-Dependent, Small Rural Hospitals Under the Hospital Inpatient Prospective Payment System; Provider Administrative Appeals and Judicial Review." *Federal Register* 80 (219). November 13, 2015.

[2] Ibid.

Reference

Centers for Medicare and Medicaid Services. "Details for title: CMS-1633-P." 2015.

Crystal Clack (crystal.clack@ahima.org) is a director of HIM practice excellence at AHIMA.

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