Hospital Outpatient Prospective Payment System Updated for 2014

By Angie Comfort, RHIT, CDIP, CCS

With only a few weeks left in 2013, the Hospital Outpatient Prospective Payment System (OPPS) final rule for calendar year (CY) 2014 was released on November 27, 2013 and went into effect on January 1, 2014. The final rule is normally provided to the public around the first week of November. Due to the delayed release and the holiday season that quickly followed, facilities faced the challenge of quickly ensuring chargemaster and abstracting systems were updated with the 2014 changes.

Two areas did not change for CY 2014. The Centers for Medicare and Medicaid Services (CMS) will continue the 7.1 percent payment adjustment for rural sole community hospitals, including essential access community hospitals. This payment is for all services and procedures paid under the OPPS, excluding separately payable drugs and biologicals, devices paid under the pass-through payment policy, and items paid at charges reduced to costs. There are no updates to the drug administration services, which have remained unchanged since 2009 when the five-level Ambulatory Payment Classification (APC) structure was created by CMS for drug administration.

Find APC Changes Quickly

Each year, there is an easy way to view changes to the HCPCS codes. Refer to Addendum B of the OPPS final rule, and view the list to see if an APC status was modified for the current year. Any code that has a comment indicator (CH) shows the reader this code has experienced a change that will be implemented during the calendar year of the final rule. By performing a sort of column C of Addendum B, it shows a total of 2,727 HCPCS codes that had some type of change for CY 2014. The changes may include new codes with a payment, APC assignment change, APC payment increase or decrease, eliminated payments, status indicator changes, or deleted codes. This addendum is located on the CMS website for the OPPS final rule.

Outpatient Clinic Visit Codes

The CY 2014 proposed OPPS rule suggested the replacement of all Evaluation and Management (E/M) codes for Type A ED and Type B ED as well as the office visit codes. The only E/M codes replaced, however, were the new and established outpatient clinic visit CPT codes (99201-99205 and 99211-99215). Hospitals were to report HCPCS code G0463, Hospital outpatient clinic visit for assessment and management of pain (APC 0634) beginning January 1, 2014 for all outpatient clinic visits. All visit levels are reimbursed with a single rate of $92.53 regardless of the acuity level of the patient. The rate was calculated by taking the mean cost from level 1 through level 5 based on CY 2012 claims data. CMS stated the change would better reflect the hospital resources involved and be more administratively simple for hospitals to utilize.

Packaged Items and Services

There are five categories that were added to the list of OPPS packaged items and services:

- Drugs, biologicals, and radiopharmaceuticals used in a diagnostic test or procedure
- Drugs and biologicals when used as supplies in a surgical procedure
- Certain clinical diagnostic laboratory tests
- Procedures described by add-on codes
- Device removal procedures

Packing policies of the final rule for CY 2014 provides rationale for the change. It confirmed that CMS believes that one code may report an item or service that was integral, ancillary, supportive, dependent, or adjunctive to the provision of care that was reported by another HCPCS code.[1] Therefore, packaging would limit misuse of reporting these items or services with selected HCPCS codes.

Drug Packaging Threshold Raised

The final rule also raised the drug packaging threshold from $80 to $90. Any drug with a mean cost per day that was less than $90 will be packaged. Fourteen drugs and biologicals lost their pass-through status for CY 2014. Five of these drugs will now be packaged and the other nine are separately payable. Table 32 in the CY 2014 OPPS final rule has a complete listing of these changes.[2]

Pass-Through Status

The OPPS policy continues with the device pass-through payments and reminds facilities that a category of devices will be eligible for the pass-through payment for at least two years, but less than three years. As of January 1, 2014, the device pass-through payment is expired for three devices: C1830, Powered bone marrow biopsy needle; C1840, Lens, intraocular (telescopic); and C1886, Catheter, extravascular tissue ablation, any modality (insertable). Going forward, the device costs will be packaged into the costs of the associated procedure. For CY 2014, there are no device categories eligible for pass-through payment.

Conversion Factor

The CY 2014 OPPS final rule includes a conversion factor increase of 1.7 percent. The OPPS conversion factor is the dollar amount the relative weights are multiplied by in order to determine the payment. For hospitals that meet the outpatient quality reporting requirements, the conversion factor is $72.672. Any hospital that does not meet these requirements must use the lower conversion factor, which for 2014 is $71.219.

Inpatient Only List

For CY 2014, there were no deletions from the inpatient only listing. However, there are four CPT codes that were added to the list for CY 2014. CPT codes 44206, Laparoscopy, surgical; colectomy, partial, with end colostomy and closure of distal segment (Hartmann type procedure); 44207, Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis); 44208, Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis) with colostomy; and 44213, Laparoscopy, surgical, mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy, will only be paid for patients receiving these procedures in an inpatient setting. There are 1,748 procedures on the inpatient only list for CY 2014. This list can be found in Addendum E of the OPPS final rule.

Outlier Policy

The outlier payment policy continues to be based on a two-threshold model with the multiplier threshold set at 1.75 but with an increase of the fixed dollar threshold and higher percentage of the outlier pool for Community Mental Health Centers (CMHC). In CY 2014, the fixed dollar amount is raised to $2,900. The outlier pool is still holding at 1 percent of total OPPS payments while the outlier pool for CMHC was increased to 0.16 percent. There were no other changes to the outlier payment policy as the remaining items of the CY 2013 policy were brought forward for CY 2014.

Two Measures Removed from Quality Reporting Program

The final rule removed two measures, OP-19 for ED transition discharge record and OP-24 Cardiac Rehab referral from outpatient settings, from the Hospital Outpatient Quality Reporting Program. The remaining 24 measures will be collected

through 2014 with payment determination occurring in 2015. Four new measures were added that will be collected in CY 2014 and will affect CY 2016 payment:

- OP-27 Influenza Vaccination Coverage among Healthcare Personnel
- OP-29 Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average-Risk Patients
- OP-30 Endoscopy/Polyp Surveillance: Colonoscopy Interval with a History of Adenomatous Polyps—Avoidance of Inappropriate Use
- OP-31 Cataracts—Improvement in Patient's Visual Function Within 90 Days Following Cataract Surgery

Final Rule Available for Review Online

There were some very significant changes to the OPPS this year. It is recommended that individuals visit the CMS website to review the 2014 OPPS Final Rule. This article only highlights some of the many changes that have been finalized for CY 2014. With any changes or updates to the coding systems, facilities should always check with their non-Medicare providers to determine if their rules have been updated as well.

Notes

1. Centers for Medicare and Medicaid Services. "Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Hospital Value-Based Purchasing Program; Organ Procurement Organizations; Quality Improvement Organizations; Electronic Health Records (EHR) Incentive Program; Provider Reimbursement Determinations and Appeals; Final Rule." *Federal Register* 78, no. 237, December 10, 2013. http://www.gpo.gov/fdsys/pkg/FR-2013-12-10/pdf/2013-28737.pdf.
2. Ibid.

Reference

Centers for Medicare and Medicaid Services. "Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Hospital Value-Based Purchasing Program; Organ Procurement Organizations; Quality Improvement Organizations; Electronic Health Records (EHR) Incentive Program; Provider Reimbursement Determinations and Appeals; Final Rule Addenda." 2013. http://www.cms.gov/apps/ama/license.asp?file=/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/CMS-1601-FC-Addenda.zip.

Angie Comfort (angie.comfort@ahima.org) is a director of HIM practice excellence at AHIMA.

Article citation:
Comfort, Angie. "Hospital Outpatient Prospective Payment System Updated for 2014" *Journal of AHIMA* 85, no.3 (March 2014): 60-62.