2019 Hospital Outpatient Prospective Payment System – Five Things to Know

1. The conversion factor to determine the payment rates under the HOPPS is updated annually. For 2019, and for hospitals that meet quality reporting requirements, the proposed conversion factor = $79.546. This constitutes a "raise," as the 2018 conversion factor is $78.636.

   For hospitals that fail to meet hospital outpatient reporting requirements, the proposed conversion factor = $77.955.

2. CMS did not address a request by ASPS to investigate the configuration of C-APCs 5092 and 5093, "*Breast/Lymphatic Surgery and Related Procedures,"* Levels 2 and 3 respectively.*

   Based on our analysis, and while not separately reimbursed, the cost of ADMs (billed via CPT code 15777) are routinely reported on claims with CPT 19340 (immediate insertion of a breast prosthesis following mastopexy, mastectomy, or in reconstruction). Actual total costs exceed $6,000 per patient. These services are assigned to APC 5092, which has a $4,811.88 payment rate. As such, the service appears to exceed the two-times rules* for APC assignment.

3. CMS is indicating a willingness to look at alternative payment structures for packaged skin substitutes*, and is seeking input on the best of the following options:
   a. Establish a lump-sum "episode-based" payment for a wound care episode.
   b. Eliminate the existing "high cost/low cost" categories for skin substitutes, and only have one payment category and one set of procedure codes for all skin substitute products.
   c. Allow for the payment of current add-on codes or create addition procedure codes to pay for skin graft services between 26 cm^2 and 99 cm^2 and substantially over 100 cm^2.
   d. Keep the high/low cost skin substitute categories, but change the threshold using to assign skin substitutes to the high-cost or low-cost group.

4. CMS proposes to continue to pay Off-campus sites that are more than 250 yards from the main campus and began providing services on or after November 2, 2015 at 40 percent of the HOPPS rate. A detailed discussion of this proposal appears in the physician fee schedule proposed rule. However, in this OPPS proposed rule CMS solicits comments on how to maintain access to new innovations while controlling for unnecessary increases in the volume of covered hospital OPD services. CMS also seeks comments on additional items and services paid under the OPPS that may represent unnecessary increases in OPD utilization and examples of when it might be appropriate for higher payments to a hospital outpatient site versus other sites-of-service.

5. As indicated in the in-patient proposed rule, as well as the physician fee schedule proposed rule, CMS is proposing medical record technology be certified to the 2015

edition of CHERT as a requirement for participation in the Electronic Health Record meaningful use (now known as promoting interoperability) program.

ADDITIONAL INFORMATION

Reconfiguring Comprehensive APCs (C-APC)

CMS defines a comprehensive APC (C-APC) as a classification system of payment that treats all individually reported codes on a hospital outpatient claim as representing components of a comprehensive service, resulting in a single prospective payment based on the cost of all individually reported codes on the claim. This payment represents the delivery of a primary service as well as all adjunct services provided to support that delivery. The APC assignment methodology includes evaluating the geometric mean costs of the primary service claims to establish resource similarity and the clinical characteristics of each procedure in that APC.

When first introduced, CMS stated that the proposal to calculate an APC relative payment weight on the geometric mean costs rather than the median cost of services within an APC "would not significantly impact most providers." Safeguards were built into the methodology to ensure resources and clinical similarities would dictate the assignment of the primary services to a specific C-APC. Should the Agency determine a primary service routinely exceeding the cost of other services in the same C-APC, it would consider promoting the service to the next highest cost C-APC within the clinical family.

Two-Times Rule

The Two-Times Rule refers to the guideline that the highest calculated cost of an individual procedure categorized to any given APC cannot exceed two times the calculated cost of the lowest costing procedure categorized to that same APC.

Of note, CMS can exempt any APC from the two-times rule for any of the following reasons:

- Resource homogeneity
- Clinical homogeneity
- Hospital concentration
- Frequency of service (volume)
- Opportunity for upcoding
- Code fragmentation

Reimbursement for Skin Substitutes

Since 2014, the Centers for Medicare & Medicaid Services (CMS) has categorized skin substitutes billed under the Hospital Outpatient Prospective Payment System (HOPPS) as either a "high" or "low" cost device, based on a complicated formula that includes averaging the "mean unit cost" of a product. Yearly updates to the formula created significant variations in payment policy, as well as total reimbursement from year to year for procedures that include skin substitutes. In 2018, the Agency indicated its willingness to limit year-to-year fluctuations in the reimbursement formula for skin substitutes in 2018 while further study of the issue takes place.