Insights to Coding and Data Quality

Review of the Medicare Outpatient Prospective Payment System Final Rule for 2014

by Nancy Andersen, MS, RHIA, CCS, CRCR

The Centers for Medicare and Medicaid Services (CMS) published the 2014 Medicare Outpatient Prospective Payment System (OPPS) and the Medicare Ambulatory Surgical Center (ASC) payment system Final Rule on November 27, 2013, and it became effective January1, 2014. There are several important changes to the OPPS and ASC payment systems as well as changes and refinements to the requirements for the Hospital Outpatient Quality Reporting (OQR) program, the ASC Quality Reporting (ASCQR) program, the Hospital Value-Based Purchasing (VBP) program, and conditions for coverage (CfCs) for organ procurement organizations (OPOs). This article is not all inclusive, but rather highlights sections of the final rule of particular interest to HIM professionals. For final rule specific details, please refer to the link included in the references at the end of this article.

Major OPPS/ASC changes

CMS continues to package hospital outpatient services to more closely resemble the Medicare inpatient prospective payment system and less like a fee schedule, including those services that are considered integral, ancillary, supportive, dependent, or adjunctive to the primary services provided. There are five new categories of packaged services for 2014.

- All drugs, biologicals, and radiopharmaceuticals that function as supplies when used in a diagnostic test or procedure, including stress agents and the drug Cysview.

- All drugs and biologicals (including implantable biologicals) that function as supplies when used in a surgical procedure, including skin substitutes. CMS states when certain drugs and biologicals are used to perform surgical procedures, they function as necessary supplies for those procedures and should be packaged.

- Clinical diagnostic laboratory tests (other than molecular pathology tests), that are integral, ancillary, supportive, dependent, or adjunctive to the primary services provided will be packaged when provided on the same date of service as the primary service AND ordered by the same practitioner who ordered the primary service. Payment for preoperative laboratory tests will be packaged into the payment for the surgery. Clinical lab tests will be paid separately only when billed on a 14x claim; the hospital will be responsible for determining when to separately bill laboratory tests on the 14x claim based on the following criteria:

    - The lab test is the only service provided on that date of service.

    - The lab test is on the same date of se-vice as the primary service but is ordered for a different purpose than the primary service by a practitioner different than the practitioner who ordered the primary service.

- All procedures described by add-on codes that are integral, ancillary, supportive, dependent, or adjunctive to the primary services provided will be packaged into the primary procedure

ambulatory classification system (APC) (excluding drug administration add-on codes and add-on codes currently assigned to device-dependent APCs).

- Device removal procedure codes billed with surgical procedures involving device repair or replacement will be packaged into the repair/replacement APC when performed with a separately coded device repair or replacement procedure. There are 71 device removal procedure codes being conditionally packaged with a status indicator "Q2;" no separate payment is made when the Current Procedural Terminology (CPT) code occurs on the same date of service as another procedure code with status indicator "T."

All hospital outpatient clinic visits under the OPPS have a new alphanumeric Healthcare Common Procedure Coding System (HCPCS) code, G0463 (hospital outpatient clinic visit for assessment and management of a patient). CMS states that payment for low acuity and high acuity patients should average out, therefore all clinic visit levels will be paid at a single rate regardless of patient acuity. The final rule also eliminated the distinction between new and established patient clinic visits. The new HCPCS code is assigned to new APC 0634. Payers outside of CMS may not recognize this new HCPCS code and may continue to require reporting of all clinic evaluation and management (E/M) CPT codes. Financial impact will depend upon the current distribution of clinic visit CPT codes for your organization and understanding the other types of services typically provided on the same date of service as clinic visits. The CMS final rule did NOT finalize the proposal to replace the current five levels of E/M codes for each type of emergency department visit. CMS will consider options to improve the codes for these services in the future.

Four new procedures were added to the "Inpatient Only" list for 2014:

- 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.

- 44213 Laparoscopy, surgical, mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy.

Ambulatory Surgical Center (ASC) Payment System changes

New HCPCS Level II and Level III codes were created in April and July 2013 for inclusion in the 2014 final rule. There were four CPT I procedure codes added to the ASC-approved list and three CPT codes permanently designated as office-based; all of these codes are listed in the tables.

Hospital Outpatient Quality Reporting (OQR) program changes

There are four new Hospital Outpatient Quality Reporting (OQR) program measures affecting CY 2016 payment determination:

- Influenza Vaccination Coverage among health care personnel.

- Endoscopy/Polyp Surveillance: Appropriate follow-up interval for normal colonoscopy in average-risk patients.

- Endoscopy/Polyp Surveillance: Colonoscopy interval for patients with a history of adenomatous polyps-avoidance of inappropriate use.

- Cataracts: Improvement in patient's visual function within 90 days following cataract surgery.

Two OQR program measures that were removed for CY 2015 payment determination:

- Transition record with specified elements received by discharged ED patients.

- Cardiac Rehabilitation Measure: Patient referral from an outpatient setting.

ASC quality reporting (ASCQR) program

In 2012 CMS finalized a policy that ASCs begin submitting data on quality measures for services as of October 1, 2012, for the CY 2014 payment determination under the ASCQR program.

In 2013 CMS finalized a methodology to calculate reduced national unadjusted payment rates using the ASCQR program reduced update conversion factor that would apply to ASCs that fail to meet their quality reporting requirements for the CY 2014 payment determination and subsequent years. ASCs that meet the quality reporting requirements will receive a 1.2 percent update for CY 2014 and ASC conversion factor of $43.471. ASCs that do not meet the quality reporting requirements will receive a decrease of –0.8 percent and the ASC conversion factor will be $42.612.

CMS has adopted new quality measures for the CY 2016 payment determination and subsequent years where data collection will begin in CY 2014. CMS is collecting aggregate data (numerators, denominators, and exclusions) on all ASC patients for these four chart-abstracted measures via an online Web-based tool located on a CMS Web page. CMS is also adopting, for the CY 2016 payment determination and subsequent years' payment determinations, requirements for a Quality Net account and security administrator, facility participation, a minimum threshold and minimum volume for claims-based measures, and data collection and submission for new measures and for certain previously finalized measures. The four new measures include:

- Complications within 30 Days following cataract surgery requiring additional surgical procedures.

- Endoscopy/Polyp Surveillance: Appropriate follow-up for normal colonoscopy in average risk patients.

- Endoscopy/Polyp Surveillance: Colonoscopy interval for patients with a history of adenomatous polyps-avoidance of inappropriate use.

- Cataracts: Improvement in patient's visual function within 90 days following cataract surgery.

Hospital Value-Based Purchasing (VBP) program
The Hospital Value-Based Purchasing (VBP) program provides value-based incentive payments to hospitals that meet certain performance standards. The 2014 final rule set performance and baseline periods for catheter-associated urinary tract infection (CAUTI), central line-associated bloodstream infection (CLABSI), and surgical site infection (SSI) measures for the FY 2016 Hospital VBP program. The final performance period is January 1, 2014 through December 31, 2014; the final baseline period was January 1, 2012 through December 31, 2012.

Organ Procurement Organizations (OPOs) conditions for coverage
OPO outcome measures are empirically based and allow comparison of an OPO's performance to the performance of its peers. OPO performance is a critical element of the organ transplantation system and encourages efficient procurement and delivery of organs to recipients.

CMS modified the current outcome measures requirement to require that OPOs meet two out of the three outcome measures instead of all three outcome measures. CMS states the majority of OPOs will be able to meet two out of the three outcome measures.

- The first outcome measure assesses an OPO's conversion rate of potential donors to actual donors to determine how an OPO has performed in regard to donor potential in its designated service area as well as how it has performed compared to other OPOs.

- The second outcome measure uses statistical methodology to determine the expected donation rate for each OPO, allowing an assessment of how an OPO has performed versus its expected performance.

- The third measure is comprised of three individual measures for organs transplanted per donor and organs used for research per donor. This third measure allows assessment of how well an OPO fulfills its mission to recover viable organs and place them with transplant centers for transplantation – as well as its commitment to placing organs for research.

Looking ahead, CMS will continue to analyze opportunities to bundle and package services. The final rule appeared in the December 10, 2013 Federal Register and can be downloaded from the Federal Register at: **http://www.ofr.gov/inspection.aspx?Asp xAutoDetectCookieSupport=1.**

New ASC Covered Surgical Procedures for CY 2014			
CY 2014 CPT CODE	**CY 2014 LONG DESCRIPTOR**	**FINAL CY2014 STATUS INDICATOR**	**CY 2014 APC**
27415	Osteochondral allograft, knee, open	T	00052
27524	Open treatment of patellar fracture, with internal fixation and/or partial or complete patellectomy and soft tissue repair	T	00063
60240	Thyroidectomy, total or complete	T	00114
60500	Parathyroidectomy or exploration of parathyroid(s)	T	00256

New Level II HCPCS Codes for Covered Surgical Procedures or Covered Ancillary Services Implemented in April and July 2013				
CY 2013 HCPCS CODE	**CY 2014 HCPCS CODE**	**CY 2014 LONG DESCRIPTOR**	**CY 2014 STATUS INDICATOR**	**CY 2014 APC**
C9130	J1556	Injection, immune globulin (Bivigam), 500 mg	G	9130
C9131	J9354	Injection, ado-trastuzumabemtansine, 1 mg	G	9131
C9297	J9262	Injection, omacetaxinemepesuccinate, 0.01 mg	G	9297
C9298	J7316	Injection, ocriplasmin, 0.125 mg	G	9298
C9734	C9734	Focused ultrasound ablation/therapeutic intervention, other than uterine leiomyomata, with magnetic resonance (MR) guidance	S	0065
C9735	C9735	Anoscopy; with directed submucosal injection(s), any substance	T	0150
C9736	0336T	Laparoscopy, surgical, radiofrequency ablation of uterine fibroid(s), including intraoperative guidance and monitoring, when performed	T	0174
G0460	G0460	Autologous platelet rich plasma for chronic wounds/ulcers, including phlebotomy, centrifugation, and all other preparatory procedures, administration and dressings, per treatment	T	0327
K0008	K0008	Custom Manual Wheelchair Base	Y	N/A
K0013	K0013	Custom Motorized/Power Wheelchair Base	Y	N/A
Q0090	J7301	Levonorgestrel-Releasing Intrauterine Contraceptive System (Skyla), 13.5 mg	E	N/A

K0900	K0900	Customized Durable Medical Equipment, Other Than Wheelchair	Y	N/A
Q0507	Q0507	Miscellaneous supply or accessory for use with an external ventricular assist device	N	N/A
Q0508	Q0508	Miscellaneous supply or accessory for use with an implanted ventricular assist device	N	N/A
Q0509	Q0509	Miscellaneous supply or accessory for use with any implanted ventricular assist device for which payment was not made under Medicare Part A	N	N/A
Q2033	90673	Influenza virus vaccine Influenza virus vaccine, trivalent, derived from recombinant DNA (RIV3), hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use	L	N/A

New Level II HCPCS Codes for Covered Surgical Procedures or Covered Ancillary Services Implemented in April and July 2013

CY 2013 HCPCS CODE	CY 2014 HCPCS CODE	CY 2014 LONG DESCRIPTOR	CY 2014 STATUS INDICATOR	CY 2014 APC
Q2050	Q2050	Injection, Doxorubicin Hydrochloride, Liposomal, Not Otherwise Specified, 10 mg	K	7046
Q2051	J3489	Injection, Zoledronic Acid, 1 mg	K	1356

NEW CATEGORY III CPT CODES IMPLEMENTED IN JULY 2013 as ASC Covered Ancillary Services

CY 2013 CPT CODE	CY 2013 LONG DESCRIPTOR	PROPOSED CY 2014 STATUS INDICATOR	FINAL CY 2014 APC
0329T	Monitoring of intraocular pressure for 24 hours or longer, unilateral or bilateral, with interpretation and report	E	N/A
0330T	Tear film imaging, unilateral or bilateral, with interpretation and report	S	230
0331T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment	S	377
0332T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment; with tomographic SPECT	S	377
0333T	Visual evoked potential, screening of visual acuity, automated	E	N/A

0334T	Sacroiliac joint stabilization for arthrodesis, percutaneous or minimally invasive (indirect visualization), includes obtaining and applying autograft or allograft (structural or morselized), when performed, includes image guidance when performed (eg, CT or fluoroscopic)	T	0052

ASC COVERED SURGICAL PROCEDURES NEWLY DESIGNATED AS PERMANENTLY OFFICE-BASED FOR CY 2014

CY 2014 CPT CODE	CY 2014 LONG DESCRIPTOR	CY 2013 ASC PAYMENT INDICATOR	PROPOSED CY 2014 ASC PAYMENT INDICATOR	FINAL CY 2014 ASC PAYMENT INDICATOR
26341	Manipulation, palmar fascial cord (ie, dupuytren's cord), post enzyme injection (eg, collagenase), single cord	G2	P3	P3
37761	Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg	G2	R2	R2
36595	Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access	G2	P3	P3

_____

References:
Department of Health and Human Services, Centers for Medicare and Medicaid Services, 42 CFR Parts 405, 410, 412, 419, 475, 476, 486 and 495 ***http:// www.ofr.gov/(X(1)S(1qfcpef2woqdakwu4rntktfi))/OFRUpload/OFRData/2013-28737_PI.pdf***
CMS Fact Sheet: MS Issues Hospital Outpatient Department and Ambulatory Surgical Center Policy and Payment Changes for 2014 ***http://www.cms. gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2013-Fact-Sheets-Items/2013-11-27-3.html***

_____

Nancy Andersen. MS, RHIA, CCS, CRCR, AHIMA-Approved ICD-10-CMPCS Trainer, Director, CHIA Board of Directors, is the Senior Compliance Manager, Care Delivery and Health Information Management National Compliance, Ethics and Integrity Office, Kaiser Permanent Foundation Health Plan, Inc., Oakland, California