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CY14 OPPS Proposed Rule Fact Sheet

Submission of Comments

This document provides an overview of the Medicare proposed rule for the Outpatient Prospective Payment System (OPPS) for calendar year 2014 (CY14). The proposed rule is available in the July 19, 2014, *Federal Register*. Additional information regarding the OPPS is available on the Centers for Medicare and Medicaid Services (CMS) web site.

CMS must receive comments on the proposal by September 6, 2013, at 5 p.m. When commenting, please refer to file code CMS-1601-P.

You may, and CMS encourages you to, submit electronic comments on the regulation to http://www.regulations.gov**.** Follow the instructions under the "submit a comment" tab.

Written comments may be sent regular mail to the following address:

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1601-P
P.O. Box 8013
Baltimore, MD 21244-1850

Written comments can also be sent via express/overnight mail to the following address:

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1601-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Overview

The Centers for Medicare & Medicaid Services (CMS) released a proposed rule with comment period that updates payment policies and rates for services furnished to Medicare beneficiaries in hospital outpatient departments and establishes payments for services furnished in ambulatory surgical centers (ASCs) beginning January 1, 2014. In addition, CMS proposes to update and refine the requirements for the Hospital Outpatient Quality Reporting (OQR) Program, the ASC Quality Reporting (ASCQR) Program, and the Hospital Value-Based Purchasing (VBP) Program.

Estimated Impact

CMS's proposal: The following table shows the estimated impact of this proposed rule on hospitals after all CY14 updates have been made. CMS provides a more comprehensive table on pages 43692 and 43693 of the final rule.

CY14 OPPS Update Impact Table

	All Changes (Percentage)
All Hospitals	1.8
Urban Hospitals	2.0
Rural Hospitals	0.9
Teaching Status	
Non-Teaching	1.2
Minor	1.8
Major	3.1

OPPS Payment Updates

Background: The estimated increase in the total payments made under the OPPS is determined largely by the increase to the conversion factor under the statutory methodology. The conversion factor is updated annually by the outpatient department (OPD) fee schedule increase factor, which is equal to the market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Social Security Act (the Act), referred to as the IPPS market basket percentage increase.

Proposed Summary: For FY14, CMS proposes to increase the payment rates under the OPPS by the average OPD fee schedule increase factor of 1.8 percent for those hospitals that submit quality data, and -0.2 percent for those that do not.

CMS's Proposal: The proposed IPPS market basket percentage increase for FY14 is **2.5** percent. Section 1833(t)(3)(F)(i) of the Act reduces that 2.5 percent by the 10-year moving average of changes in annual economy-wide, private nonfarm business multifactor productivity (MFP) described in section 1886(b)(3)(B)(xi)(II) of the Act, which is proposed to be **0.4** percent for FY14 (also the proposed MFP adjustment for FY14 in the FY14 IPPS/LTCH PPS proposed rule). The market basket percentage increase is further reduced by an additional **0.3** percent, in

accordance with sections 1833(t)(3)(F)(ii) and 1833(t)(3)(G)(iii) of the Act, resulting in the proposed OPD fee schedule increase factor of **1.8** percent, which CMS is proposing to use in the calculation of the proposed CY14 OPPS conversion factor.

Hospitals that fail to meet the Hospital OQR Program reporting requirements are subject to an additional reduction of **2.0** percent from the OPD fee schedule increase factor adjustment to the conversion factor that would be used to calculate the OPPS payment rates for their services. As a result, those hospitals failing to meet the Hospital OQR Program reporting requirements would receive an OPD fee schedule increase factor of -0.2 percent (which is 2.5 percent, the proposed estimate of the hospital inpatient market basket percentage increase, less the proposed 0.4 percent MFP adjustment, the 0.3 percent additional adjustment, and finally the 2.0 percent for the Hospital OQR Program reduction).

The table below reflects the CY14 OPPS proposed payment update calculations for hospitals that submit quality data and those that do not.

Impact of Proposed CY14 OPPS Updates

Market Basket Increase	(Minus) MFP Adjustment	(Minus) Additional Reduction	**FY14 Proposed Payment Increase**
2.5	0.4	0.3	**1.8**

Impact of Proposed CY14 OPPS Updates (No Quality Data)

Market Basket Increase	(Minus) MFP Adjustment	(Minus) Additional Reduction	(Minus) Hospital OQR Reduction	**FY14 Payment Increase**
2.5	0.4	0.3	2.0	**-0.2**

Conversion Factor Update
Federal Register pages 191-197

Proposal Summary: The proposed conversion factor for CY14 is **$72.728**. To set the OPPS conversion factor for CY14, CMS is proposing to increase the CY13 conversion factor of $71.313 by 1.8 percent.

Background: Section 1833(t)(3)(C)(ii) of the Act requires the HHS Secretary to update the conversion factor used to determine the payment rates under the OPPS on an annual basis by applying the OPD fee schedule increase factor. The OPD fee schedule increase factor is equal to the hospital inpatient market basket percentage increase applicable to hospital discharges under section 1886(b)(3)(B)(iii) of the Act.

CMS's Proposal: To set the OPPS conversion factor for CY14, CMS is proposing to increase the CY13 conversion factor of $71.313 by 1.8 percent. In accordance with section 1833(t)(9)(B) of the Act, CMS is also proposing to further adjust the conversion factor for CY14 to ensure that any revisions made to the updates for a revised wage index and rural adjustment are made on a budget neutral basis. CMS would calculate an overall proposed budget neutrality factor of **1.004**

for wage index changes by comparing proposed total estimated payments from its simulation model using the proposed FY14 IPPS wage indices to those payments using the current (FY13) IPPS wage indices, as adopted on a calendar year basis for the OPPS. For CY14, CMS is not proposing to make a change to its rural adjustment policy. Therefore, **the proposed budget neutrality factor for the rural adjustment is 1.0000**.

CMS estimates that pass-through spending for both drugs and biologicals and devices for CY14 would equal approximately $12 million, which represents 0.02 percent of total projected CY14 OPPS spending. Therefore, the proposed conversion factor also would be adjusted by the difference between the 0.15 percent estimate of pass-through spending for CY13 and the 0.02 percent estimate of CY14 pass-through spending, resulting in a proposed adjustment for CY14 of **0.13** percent. Estimated payments for outliers would remain at **1.0** percent of total OPPS payments for CY14.

The proposed OPD fee schedule increase factor of 1.8 percent for CY14, the required proposed wage index budget neutrality adjustment of approximately 1.0004, the proposed cancer hospital payment adjustment of 1.0001, and the proposed adjustment of 0.13 percent of projected OPPS spending for the difference in the pass-through spending result in a proposed conversion factor for CY14 of **$72.728**.

Hospitals that fail to meet the reporting requirements of the Hospital OQR Program would continue to be subject to a further reduction of 2.0 percent to the OPD fee schedule increase factor adjustment to the conversion factor that would be used to calculate the OPPS payment rates made for their services. To calculate the proposed CY14 reduced market basket conversion factor for those hospitals that fail to meet the requirements of the Hospital OQR Program for the full CY14 payment update, CMS is proposing to make all other adjustments discussed above, but using a proposed reduced OPD fee schedule update factor of –0.2 percent. This would result in a proposed reduced conversion factor for CY14 of **$71.273** for those hospitals that fail to meet the Hospital OQR requirements (a difference of -$1.455 in the conversion factor relative to those hospitals that met the Hospital OQR requirements).

Hospital Outpatient Outlier Payments
Federal Register pages: 214-220

Proposal Summary: CMS proposes a fixed-dollar threshold of $2,775 for FY14. The FY13 fixed dollar threshold was $2,025.

Background: Currently, the OPPS provides outlier payments on a service-by-service basis. It has been CMS's policy for the past several years to report the actual amount of outlier payments as a percent of total spending in the claims being used to model the proposed OPPS. The current estimate of total outlier payments as a percent of total CY12 OPPS payment, using available CY12 claims and the revised OPPS expenditure estimate for the 2013 Trustee's Report, is approximately 1.1 percent of the total aggregated OPPS payments. Therefore, for CY12, CMS estimates that it paid 0.1 percent above the CY12 outlier target of 1.0 percent of total aggregated OPPS payments. As explained in the CY13 OPPS/ASC final rule with comment period, CMS set

its projected target for aggregate outlier payments at 1.0 percent of the estimated aggregate total payments under the OPPS for CY13. Using CY12 claims data and CY13 payment rates, CMS currently estimates that the aggregate outlier payments for CY13 will be approximately 1.2 percent of the total CY13 OPPS payments.

CMS's Proposal: For CY14, CMS is proposing to continue its policy of estimating outlier payments to be 1 percent of the estimated aggregate total payments under the OPPS for outlier payments. A portion of that 1 percent, an amount equal to 0.18 percent of outlier payments (or 0.0018 percent of total OPPS payments) would be allocated to community mental health centers (CMHCs) for partial hospitalization program (PHP) outlier payments. This is the amount of estimated outlier payments that would result from the proposed CMHC outlier threshold as a proportion of total estimated OPPS outlier payments. For CMHCs, CMS would continue its longstanding policy that if a CMHC's cost for partial hospitalization services, paid under either APC 0172 (Level I Partial Hospitalization (3 services) for CMHCs) or APC 0173 (Level II Partial Hospitalization (4 or more services) for CMHCs), exceeds 3.40 times the payment rate for APC 0173, the outlier payment would be calculated as 50 percent of the amount by which the cost exceeds 3.40 times the APC 0173 payment rate.

CMS aggregated CY14 hospital outlier payments using the cost to charge ratios for several different fixed-dollar thresholds, holding the 1.75 multiple threshold constant and assuming that outlier payments would continue to be made at 50 percent of the amount by which the cost of furnishing the service would exceed 1.75 times the APC payment amount, until the total outlier payments equaled 1.0 percent of aggregated estimated total CY14 OPPS payments. CMS estimated that a proposed fixed-dollar threshold of **$2,775**, combined with the proposed multiple threshold of 1.75 times the APC payment rate, would allocate 1.0 percent of aggregated total OPPS payments to outlier payments. CMS would continue to make an outlier payment that equals 50 percent of the amount by which the cost of furnishing the service exceeds 1.75 times the APC payment amount when both the 1.75 multiple threshold and the proposed fixed-dollar threshold of $2,775 are met. The fixed-dollar threshold for 2013 was **$2,025**.

For hospitals that fail to meet the Hospital OQR Program requirements, CMS is proposing to continue the policy that it implemented in CY10 that the hospitals' costs will be compared to the reduced payments for purposes of outlier eligibility and payment calculation.

Wage Index Changes
Federal Register pages 197- 202

Proposal Summary: For the CY14 OPPS, frontier state hospitals would receive a wage index of 1.00 if the otherwise applicable wage index (including reclassification, rural and imputed floor, and rural floor budget neutrality) is less than 1.00.

Background: Section 1833(t)(2)(D) of the Act requires the Secretary to "determine a wage adjustment factor to adjust the portion of payment and coinsurance attributable to labor-related costs for relative differences in labor and labor-related costs across geographic regions in a budget neutral manner. This portion of the OPPS payment rate is called the OPPS labor-related

share. The OPPS labor-related share is 60 percent of the national OPPS payment. This labor-related share is based on a regression analysis that determined that, for all hospitals, approximately 60 percent of the costs of services paid under the OPPS were attributable to wage costs. CMS continues to believe that using the IPPS wage index as the source of an adjustment factor for the OPPS is reasonable and logical, given the inseparable, subordinate status of the hospital outpatient department (HOPD) within the hospital overall. The IPPS wage indices are used for calculating OPPS payments.

CMS's Proposal: CMS confirmed that the labor-related share for outpatient services is appropriate during its regression analysis for the payment adjustment for rural hospitals in the CY06 OPPS final rule with comment period (70 FR 68553). Therefore, it is not proposing to revise this policy for the CY14 OPPS. *CMS refers readers to section II.H. of the proposed rule for a description and example of how the wage index for a particular hospital is used to determine the payment for the hospital.*

For the CY14 OPPS, frontier state hospitals would receive a wage index of 1.00 if the otherwise applicable wage index (including reclassification, rural and imputed floor, and rural floor budget neutrality) is less than 1.00. Also, if the associated hospital is located in a frontier state, the wage index adjustment applicable for the hospital would also apply for the affiliated HOPD.

CMS is proposing to continue its policy for CY14 of allowing non-IPPS hospitals paid under the OPPS to qualify for the out-migration adjustment if they are located in a section 505 out-migration county.

CMS refers readers to the CMS web site for the OPPS at: http://www.cms.gov/Medicare/Medicare-Fee-for- Service\Payment/HospitalOutpatientPPS/index.html where they will find a link to the proposed FY14 IPPS wage index tables.

Adjustment for Rural SCHs and EACHs
Federal Register pages 207-209

Proposal Summary: For the CY14 OPPS, CMS would continue its policy of a 7.1 percent payment adjustment that is done in a budget neutral manner for rural sole community hospitals (SCHs), including essential access community hospitals (EACHs).

Background: In the CY06 OPPS final rule with comment period, CMS finalized a payment increase for rural SCHs of 7.1 percent for all services and procedures paid under the OPPS, excluding drugs, biologicals, brachytherapy sources, and devices paid under the pass-through payment policy. This increase was made after CMS found that a difference in cost by APC existed between hospitals in rural areas and hospitals in urban areas. This adjustment for rural SCHs is budget neutral and applied before calculating outliers and copayments.

CMS's Proposal: For the CY14 OPPS, CMS is proposing to continue its policy of a 7.1 percent payment adjustment that is done in a budget neutral manner for rural SCHs, including EACHs,

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.

Cancer Hospital Payment Adjustment
Federal Register pages 209-214

Proposal Summary: Additional Payments to cancer hospital would result in a proposed target payment-to-cost ratio (PCR) equal to 0.90.

Background: There are currently 11 cancer hospitals that meet the classification criteria in section 1886(d)(1)(B)(v) of the Act that are exempted from payment under the IPPS. After conducting a study required by section 1833(t)(18)(A) of the Act, CMS determined in 2011 that outpatient costs incurred by the 11 specified cancer hospitals were greater than the costs incurred by other OPPS hospitals. Based on these findings, CMS finalized a policy to provide a payment adjustment to the 11 specified cancer hospitals that reflects the higher outpatient costs. Specifically, CMS adopted a policy to provide additional payments to each of the 11 cancer hospitals so that each hospital's final PCR for services provided in a given calendar year is equal to the weighted average PCR (which it refers to as the "target PCR") for other hospitals paid under the OPPS.

CMS's Proposal: For CY14, CMS is proposing to continue its policy to provide additional payments to cancer hospitals so that each cancer hospital's final PCR is equal to the weighted average PCR (or "target PCR") for the other OPPS hospitals using the most recent submitted or settled cost report data that are available at the time of the development of this proposed rule. To calculate the proposed CY14 target PCR, CMS used the same extract of cost report data from HCRIS, as discussed in section II.A. of the proposed rule, used to estimate costs for the CY14 OPPS. CMS is proposing a target PCR of 0.90 to determine the CY14 cancer hospital payment adjustment to be paid at cost report settlement. Therefore, the payment amount associated with the cancer hospital payment adjustment to be determined at cost report settlement would be the additional payment needed to result in a proposed target PCR equal to 0.90 for each cancer hospital. Table 10 of the proposal indicates the estimated percentage increase in OPPS payments to each cancer hospital for CY14 due to the cancer hospital payment adjustment policy.

Packaged Services
Federal Register: pages 156-186

Background: The OPPS packages payment for multiple interrelated items and services into a single payment to create incentives for hospitals to furnish services in the most efficient way by enabling hospitals to manage their resources with maximum flexibility, thereby encouraging long-term cost containment.

CMS's Proposal: Beginning in 2014, CMS is proposing to conditionally or unconditionally package the following items and services and to add them to the list of OPPS packaged items and services in 42 CFR 419.2(b):

1. Drugs, biologicals, and radiopharmaceuticals that function as supplies in a diagnostic test or procedure
2. Drugs and biologicals that function as supplies or devices in a surgical procedure
3. Laboratory tests
4. Procedures described by add-on codes
5. Ancillary services (status indicator "X")
6. Diagnostic tests on the bypass list
7. Device removal procedures

CMS believes that each of the above proposed unconditionally or conditionally packaged categories of items or services is appropriate according to existing packaging policies or expansions of existing packaging policies. The HCPCS codes that it proposes to be packaged either unconditionally (for which it proposes to assign status indicator "N"), or conditionally (for which it proposes to assign status indicator "Q1" or "Q2"), for CY14 are displayed in both Addendum P and Addendum B of the proposed rule.

The supporting documents for this proposed rule, including but not limited to the Addenda, are available at the CMS web site at: http://www.cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html.

CMS refer readers to section II.A.3. of the proposed rule for a complete description of its 2014 packaging proposals.

Pass-through Payments for Devices
Federal Register pages 261-274

Background: Section 1833(t)(6)(B)(iii) of the Act requires that, under the OPPS, a category of devices be eligible for transitional pass-through payments for at least 2, but not more than 3 years. This pass-through payment eligibility period begins with the first date on which transitional pass-through payments may be made for any medical device that is described by the category. CMS may establish a new device category for pass-through payment in any quarter. Under its established policy, CMS bases the pass-through status expiration date for a device category on the date on which pass-through payment is effective for the category, which is the first date on which pass-through payment may be made for any medical device that is described by such category. CMS proposes and finalizes the dates for expiration of pass-through status for device categories as part of the OPPS annual update.

CMS's Proposals
Expiration of Transitional Pass-Through Payments for Certain Devices
With the expiration of the three device categories eligible for pass-through payment (HCPCS codes C1830, C1840, and C1886 at the end of CY 2013), there are no currently active categories for which CMS would propose expiration of pass-through status in CY14.

Proposed Provisions for Reducing Transitional Pass-through Payments to Offset Costs Packaged into APC Groups

CMS is proposing to update the list of all procedural APCs with the final CY14 portions of the APC payment amounts that it determines are associated with the cost of devices on the CMS web site at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html so that this information is available for use by the public in developing potential CY14 device pass-through payment applications and by CMS in reviewing those applications.

Proposed Adjustment to OPPS Payment for No Cost/Full Credit and Partial Credit Devices

Beginning in CY14, CMS is proposing to modify the existing policy of reducing OPPS payment for specified APCs when a hospital furnishes a specified device without cost or with a full or partial credit. Under the proposal, CMS would reduce OPPS payment for the applicable APCs listed in Table 17 of the rule by the full or partial credit a provider receives for a replaced device. Specifically, hospitals would be required to report the amount of the credit in the amount portion for value code "FD" (Credit Received from the Manufacturer for a Replaced Medical Device) when the hospital receives a credit for a replaced device (listed in Table 18 of the proposed rule) that is 50 percent or greater than the cost of the device. Under this proposal, hospitals would no longer be required to append the "FB" or "FC" modifier when receiving a device at no cost or with a full or partial credit.

Payments for Hospital Outpatient Visits

Federal Register pages 337-344

Proposal Summary: CMS proposes to create three new alphanumeric Level II HCPCS codes to describe all levels of each type of clinic and ED visit.

Background: Currently, hospitals report HCPCS visit codes to describe three types of OPPS services: clinic visits, emergency department (ED) visits, and critical care services, including trauma team activation. Historically, CMS has recognized the CPT and HCPCS codes describing clinic visits, Type A and Type B (ED) visits, and critical care services, which are listed in Table 28 of the proposed rule.

CMS's Proposal: For CY14, CMS is proposing to modify its longstanding policies related to hospital outpatient clinic and ED visits. Rather than recognizing five levels of clinic and ED visits respectively, CMS would create three new alphanumeric Level II HCPCS codes to describe all levels of each type of clinic and ED visit. Under the proposal, CMS would create a new alphanumeric HCPCS code (GXXXC) for hospital use only representing any clinic visit under the OPPS and assign the newly created alphanumeric clinic visit HCPCS code to its own newly created APC 0634. CMS is also proposing to create a new alphanumeric HCPCS code (GXXXA) for hospital use only representing any Type A ED visit under the OPPS, and assign the newly created alphanumeric Type A ED visit HCPCS code to its own newly created APC 0635. Similarly, CMS would also create a new alphanumeric HCPCS code (GXXXB)

representing all Type B ED visits under the OPPS, and assign the newly created alphanumeric Type B ED HCPCS code to its own newly created APC 0636.

Partial Hospitalization Payments APC Update
Federal Register pages: 360-363

Proposal Summary: Level I PHP services would increase from approximately $87 to approximately $95 for CY14, and the proposed geometric mean per diem costs for Level II PHP services would decrease from approximately $113 to approximately $106 for CY14.

Background: In the CY13 OPPS/ASC final rule with comment period, CMS finalized its proposal to base the relative payment weights that underpin the OPPS APCs, including the four PHP APCs, on geometric means rather than on the medians. For CY13, it established the four PHP APC per diem payment rates based on geometric mean cost levels calculated using the most recent claims data for each provider type. *CMS refers readers to the CY13 OPPS/ASC final rule with comment period for a more detailed discussion.*

CMS's Proposal: For CY14, CMS proposes to apply its established policies to calculate the four PHP APC per diem payment rates based on geometric mean per diem costs using the most recent claims data for each provider type. CMS computed proposed CMHC PHP APC geometric mean per diem costs for Level I (3 services per day) and Level II (4 or more services per day) PHP services using only CY12 CMHC claims data, and proposed hospital-based PHP APC geometric mean per diem costs for Level I and Level II PHP services using only CY12 hospital-based PHP claims data. These proposed geometric mean per diem costs are shown in the table below (Table 30 of the proposed rule).

The proposed CY14 geometric mean per diem costs for the PHP APCs are shown below (Tables 31 and 32 of the proposed rule).

APC	Group Title	Proposed Geometric Mean Per Diem Costs
0172	Level I Partial Hospitalization (3 services) for CMHCs	$94.51
0173	Level II Partial Hospitalization (4 or more services) for CMHCs	$106.20

APC	Group Title	Proposed Geometric Mean Per Diem Costs
0175	Level I Partial Hospitalization (3 services) for hospital-based PHPs	$212.85
0176	Level II Partial Hospitalization (4 or more services) for hospital-based PHPs	$215.13

For CY14, the proposed geometric mean per diem costs for days with 3 services (Level I) is approximately $94.51 for CMHCs and approximately $212.85 for hospital-based PHPs. The proposed geometric mean per diem costs for days with 4 or more services (Level II) is approximately $106.20 for CMHCs and approximately $215.13 for hospital-based PHPs. The proposed geometric mean per diem costs for CMHCs continue to be substantially lower than the proposed geometric mean per diem costs for hospital-based PHPs for the same level of service provided, which indicates that there continues to be fundamental differences between the cost structures of CMHCs and hospital-based PHPs.

The CY14 proposed geometric mean per diem costs for CMHCs calculated under the proposed CY14 methodology using CY12 claims data have remained relatively constant when compared to the CY13 final geometric mean per diem costs for CMHCs established in the CY13 OPPS/ASC final rule with comment period, with proposed geometric mean per diem costs for Level I PHP services increasing from approximately $87 to approximately $95 for CY14, and proposed geometric mean per diem costs for Level II PHP services decreasing from approximately $113 to approximately $106 for CY14.

CMS notes that the CY14 proposed geometric mean per diem costs for hospital-based PHPs calculated under the proposed CY14 methodology using CY12 claims data show more variation when compared to the CY13 final geometric mean per diem costs for hospital-based PHPs, with proposed geometric mean per diem costs for Level I PHP services increasing from approximately $186 to approximately $213 for CY14, and proposed geometric mean per diem costs for Level II PHP services decreasing from approximately $235 to approximately $215 for CY14. CMS is considering a number of possible future initiatives that may help to ensure the long-term stability of PHPs and further improve the accuracy of payment for PHP services

OPPS Payment Status and Comment Indicators
Federal Register pages 390-394

Background: Payment status indicators (SIs) that CMS assigns to HCPCS codes and APCs serve an important role in determining payment for services under the OPPS. They indicate whether a service represented by a HCPCS code is payable under the OPPS or another payment system and also whether particular OPPS policies apply to the code.

The complete list of the proposed CY14 SIs and their definitions is displayed in Addendum D1 on the CMS web site at: http://www.cms.gov/Medicare/Medicare-Feefor- Service

Payment/HospitalOutpatientPPS/index.html and the proposed CY14 SI assignments for APCs and HCPCS codes are shown in Addenda A and B, respectively, on the CMS web site at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html.

CMS's Proposal

CY14 Payment Status Indicator Definitions

For CY14, CMS is proposing to create a new status indicator "J1" to identify HCPCS codes that are paid under a comprehensive APC. A claim with the new proposed status indicator "J1" will trigger a comprehensive APC payment for the claim. The comprehensive APCs that CMS is proposing to establish are described in detail in section II.A.2.e. of the proposed rule. For CY14, CMS is proposing to delete status indicator "X" and assign ancillary services currently assigned to status indicator "X" to either status indicator "Q1" or "S", and revise the definitions of status indicators "S" and "T" to remove the word "significant" from these definitions. In addition, CMS is proposing to update the definition of status indicator "A" for CY14.

In addition, CMS is proposing to remove "Routine Dialysis Services for End-stage Renal Disease Patients Provided in a Certified Dialysis Unit of a Hospital" from the list of items and services applicable for the definition of status indicator "A" because these services are not recognized by OPPS when submitted on an outpatient hospital Part B bill type and are instead assigned to status indicator "B."

CY14 Comment Indicator Definitions

For the CY14 OPPS, CMS is proposing to use the same two comment indicators that are in effect for the CY13 OPPS:

- "CH"—Active HCPCS codes in current and next calendar year; status indicator and/or APC assignment have changed or active HCPCS code that will be discontinued at the end of the current calendar year.

- "NI"—New code for the next calendar year or existing code with substantial revision to its code descriptor in the next calendar year as compared to current calendar year, interim APC assignment; comments will be accepted on the interim APC assignment for the new code.

CMS believes that the CY13 definitions of the OPPS status indicators continue to be appropriate for CY14.. Therefore, CMS is proposing to continue to use those definitions without modification for CY14.

Application of Therapy Caps in CAHs

Federal Register pages 376-377

Proposal Summary: CMS is proposing to continue the methodology required by the American Taxpayer Relief Act of 2012 (ATRA), which required that therapy services furnished by a critical access hospital (CAH) during 2013 are counted toward the therapy caps using the MPFS rate for 2014 and subsequent years.

Background: For outpatient physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) (collectively, "outpatient therapy") services covered under Medicare Part B, section 1833(g) of the Act applies annual, per beneficiary limitations on incurred expenses, commonly referred to as "therapy caps."

CMS's Proposal: There is one therapy cap for OT services and another separate therapy cap for PT and SLP services combined. In the CY14 Medicare Physician Fee Schedule (MPFS) proposed rule, CMS is proposing to subject outpatient therapy services that are furnished by a CAH to the therapy caps, the exceptions process, and the manual medical review process beginning on January 1, 2014. ATRA required that therapy services furnished by a CAH during 2013 are counted toward the therapy caps using the MPFS rate, and CMS is proposing to continue this methodology for 2014 and subsequent years. CAHs would still be paid for therapy services under the reasonable cost methodology for CAH outpatient services described at section 1834(g) of the Act.

Hospital OQR Program Updates
Federal Register pages 450-514

Background: CMS has implemented quality measure reporting programs for multiple settings of care. These programs promote higher quality, more efficient health care for Medicare beneficiaries. The quality data reporting program for hospital outpatient care, known as the Hospital OQR Program, formerly known as the Hospital Outpatient Quality Data Reporting Program, has been generally modeled after the quality data reporting program for hospital inpatient services known as the Hospital Inpatient Quality Reporting Program (formerly known as the Reporting Hospital Quality Data for Annual Payment Update Program). Both of these quality reporting programs for hospital services have financial incentives for the reporting of quality data to CMS. In implementing the Hospital OQR Program and other quality reporting programs, CMS has focused on measures that have high impact and support national priorities for improved quality and efficiency of care for Medicare beneficiaries as reflected in the National Quality Strategy, as well as conditions for which wide cost and treatment variations have been reported, despite established clinical guidelines.

CMS's Proposal: CMS proposes to remove the following two measures:

- *Transition Record with Specified Elements Received by Discharged ED Patients* (OP-19), because this measure cannot be implemented with the degree of specificity that would be needed to fully address safety concerns related to confidentiality without being overly burdensome

- *Cardiac Rehabilitation Measure: Patient Referral from an Outpatient Setting* (OP-24), due to continued difficulties with defining the measure care setting

The 25 quality measures previously adopted for the CY14 and CY15 payment determinations and subsequent years under the Hospital OQR Program can be found in Appendix 1. This list includes measures CMS is proposing to remove in the proposed rule.

CMS is proposing to adopt five new measures for the Hospital OQR Program for the CY16 payment determination and subsequent years, including one HAI measure, and four chart abstracted measures.

HAI measure

- Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431), currently collected by the Centers for Disease Control and Prevention (CDC) via the National Healthcare Safety Network (NHSN)

Chart-abstracted measure

- Complications within 30 days following cataract surgery requiring additional surgical procedures (NQF #0564)
- Endoscopy/poly surveillance: appropriate follow-up interval for normal colonoscopy in average risk patients (NQF #0658)
- Endoscopy/poly surveillance: colonoscopy interval for patients with a history of adenomatous polyps
- Avoidance of inappropriate use (NQF #0659)
- Cataracts: improvement in patient's visional function within 90 days following cataract surgery (NQF #1536)

All five of the proposed measures are NQF-endorsed, and therefore meet the requirements that measures selected for the program "reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities" under section 1833(t)(17)(C)(i) of the Act. Furthermore, the services targeted in the proposed measures are services commonly provided to patients who visit HOPDs and, for this reason, CMS believes that these proposed measures are appropriate for the measurement of quality of care furnished by hospitals in outpatient settings.

CMS is also proposing to collect aggregate data (numerators, denominators, exclusions) for the four chart-abstracted measures via an online, web-based tool that will be made available to HOPDs via the QualityNet web site. This tool is currently in use in the Hospital OQR Program to collect structural measure information.

To its efforts to collect high quality data for the Hospital OQR measures while minimizing the burden for HOPDs, CMS also seeks public comment on whether it should collect patient-level data via certified EHR technology on the four proposed measures excluding the Influenza Vaccination Coverage among Healthcare Personnel measure, and the potential timing for doing so.

The proposed measure set for the Hospital OQR Program for the CY16 payment determination and subsequent years is listed in Appendix 2.

Reporting Ratio Application and Associated Adjustment Policy for CY14
CMS is proposing to continue its established policy of applying the reduction of the OPD fee schedule increase factor through the use of a reporting ratio for those hospitals that fail to meet the Hospital OQR Program requirements for the full CY14 annual payment update factor. For the CY14 OPPS, the proposed reporting ratio is 0.980, calculated by dividing the proposed reduced conversion factor of $71.273 by the proposed full conversion factor of $72.728. CMS would continue to apply the reporting ratio to all services calculated using the OPPS conversion factor, and continue to apply the reporting ratio to the national unadjusted payment rates and the minimum unadjusted and national unadjusted copayment rates of all applicable services for those hospitals that fail to meet the Hospital OQR Program reporting requirements. CMS would also continue to apply all other applicable standard adjustments to the OPPS national unadjusted payment rates for hospitals that fail to meet the requirements of the Hospital OQR Program. Similarly, it would continue to calculate OPPS outlier eligibility and outlier payment based on the reduced payment rates for those hospitals that fail to meet the reporting requirements.

Hospital Value-Based Purchasing (VBP) Program Updates
Federal Register pages 514-518

Background: Section 1886(o) of the Act, as added by section 3001(a)(1) of the Affordable Care Act (ACA) requires the Secretary to establish a hospital value-based purchasing program (the Hospital VBP Program), under which value-based incentive payments are made in a fiscal year to hospitals that meet performance standards established for a performance period for such fiscal year. Both the performance standards and the performance period for a fiscal year are to be established by the HHS Secretary.

Proposal for Additional CMS Appeals Review Process
In the proposed rule for the Hospital VBP Program, CMS is proposing to implement an independent CMS review that will be an additional appeal process available to the hospitals beyond the existing review and corrections process and appeal process. Under the proposal, a hospital would be able to request this additional independent CMS review only if it first completes the appeal process and is dissatisfied with the result. CMS believes that its proposal to require hospitals to complete the existing appeal process before they can request an additional independent CMS review will facilitate the efficient resolution of many disputed issues, thus decreasing the number of independent CMS reviews that are requested. CMS intends to provide hospitals with an independent review decision within 90 calendar days following the receipt of a hospital's independent review request.

Performance and Baseline Periods for FY16 Outcome Measures
CMS proposed to adopt catheter-associated urinary tract infections (CLABSI), central line-associated bloodstream infection (CAUTI), and surgical site infection (SSI) which are measures reported to CDC's National Healthcare Safety Network (NHSN), for the FY16 Hospital VBP Program. However, when that proposed rule was published, it inadvertently did not make FY16

performance and baseline period proposals for the proposed measures. Therefore, CMS is proposing to adopt the following FY16 performance and baseline periods for these measures so that it has enough time to consider and respond to public comments before the proposed start of the performance periods.

Proposed Performance and Baseline Periods for CAUTI/CLABSI/SSI under the FY 2016 Hospital VBP Program		
Domain	**Baseline Period**	**Performance Period**
Outcome • CAUTI / CLABSI / SSI	• January 1, 2012 – December 31, 2012	• January 1, 2014 – December 31, 2014

Supervision of Hospital Outpatient Therapeutic Services
Federal Register pages 371-376

Proposal Summary: All outpatient therapeutic services furnished in hospitals and CAHs would require a minimum of direct supervision unless the service is on the list of services that may be furnished under general supervision or is designated as a nonsurgical extended duration therapeutic service.

Background: In the CY09 OPPS/ASC proposed rule and final rule with comment period, CMS clarified that direct supervision is required for hospital outpatient therapeutic services covered and paid by Medicare in hospitals as well as in provider-based departments of hospitals, as set forth in the CY 2000 OPPS final rule with comment period.

CMS's Proposal: CMS says it believes it is appropriate to allow the enforcement instruction for the supervision of hospital outpatient therapeutic services to expire at the end of CY13. Therefore, for CY14, CMS anticipates allowing the enforcement instruction to expire, such that all outpatient therapeutic services furnished in hospitals and CAHs would require a minimum of direct supervision unless the service is on the list of services that may be furnished under general supervision or is designated as a nonsurgical extended duration therapeutic service (the list of services is available on the CMS web site at http://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/HospitalOutpatientPPS/Downloads/CY2013-OPPS-General-Supervision.pdf

II. AMBULATORY SURGICAL CENTERS (ASCs)

Calculation of the ASC Payment Rates
Federal Register pages 441- 450

Proposal Summary: The proposed ASC conversion factor for FY14 is **$$43.321** for those hospitals that submit quality data, and **$42.642** for those that do not. The CY13 ASC conversion factor is $42.917.

Background: The ASC payment system is updated annually by the consumer price index for all urban consumers (CPI-U). ASC payment rates are calculated by multiplying the ASC conversion

factor by the ASC relative payment weight. Beginning in CY11, the ACA requires that the annual update to the ASC payment system (which currently is the CPI-U) after application of any quality reporting reduction be reduced by a productivity adjustment.

CMS's Proposal: CMS is proposing to set the CY14 ASC relative payment weights by scaling the proposed CY14 OPPS relative payment weights by the proposed ASC scaler of 0.8961. For CY14, CMS is proposing to increase payment rates under the ASC payment system by **0.9 percent** for ASCs meeting quality reporting requirements. This proposed increase is based on a projected CPI-U update of **1.4 percent**, minus the MFP adjustment required by the ACA, projected to be **0.5 percent**.

The following table displays the CY14 proposed rate update calculations under the ASC payment system.

CPI-U update	(Minus) MFP Adjustment	**MFP-Adjusted CPI-U Update**
1.4 %	0.5%	**0.9 %**

CMS calculated the proposed CY14 ASC conversion factor by adjusting the CY13 ASC conversion factor ($42.917) by the wage adjustment for budget neutrality of 1.0004 to account for changes in the pre-floor and pre-reclassified hospital wage indices between CY13 and CY14 and by applying the proposed CY14 MFP-adjusted CPI-U update factor of 0.9 percent (projected CPI-U update of 1.4 percent minus a projected productivity adjustment of 0.5. percent), resulting in the proposed CY14 ASC conversion factor of **$43.321**.

CMS is also proposing to reduce the CPI-U update of 1.4 percent by 2.0 percent for ASCs that do not meet the quality reporting requirements, and then apply the 0.5 percentage point MFP reduction. CMS would, therefore, apply a -1.1 percent quality reporting/MFP-adjusted CPI-U update factor to the CY13 ASC conversion factor ($42.917) for ASCs not meeting the quality reporting requirements, resulting in a proposed CY14 ASC conversion factor of **$42.642**.

Based on this proposed update, CMS estimates that total payments to ASCs (including beneficiary cost-sharing and estimated changes in enrollment, utilization, and case-mix) for CY14 would be approximately $3.980 billion, an increase of approximately $133 million compared to estimated CY13 payments.

Addenda AA and BB to the proposed rule (which are available via the internet on the CMS web site) display the proposed updated ASC payment rates for CY14 for covered surgical and ancillary services, respectively. These addenda contain several types of information related to the proposed CY14 payment rates.

The following table displays the CY14 proposed rate update calculations under the ASC payment system for those ASCs not meeting quality reporting requirements.

CPI-U update	Hospital OQR Reduction	(Minus) MFP Adjustment	**MFP-Adjusted CPI-U Update**
1.4 %	2.0%	0.5%	**-1.1 %**

Payment for Covered Ancillary Services
Federal Register pages 428- 431

Background: The final payment policies under the revised ASC payment system for covered ancillary services vary according to the particular type of service and its payment policy under the OPPS. Devices that are eligible for pass-through payment under the OPPS are separately paid under the ASC payment system. Currently, the three devices that are eligible for pass-through payment in the OPPS are described by HCPCS code C1830 (Powered bone marrow biopsy needle), HCPCS code C1840 (Lens, intraocular (telescopic)), and HCPCS code C1886 (Catheter, extravascular tissue ablation, any modality (insertable)). Payment amounts for these HCPCS codes under the ASC payment system are contractor priced. In the CY13 OPPS/ASC final rule, CMS finalized the expiration of pass-through payment for these codes, which will expire after December 31, 2013. Thereafter, the costs for devices described by them will be packaged into the costs of the procedures with which the devices are reported in the hospital claims data used in the development of the OPPS relative payment weights that will be used to establish ASC payment rates for CY14.

Ambulatory Surgical Center Quality Reporting (ASCQR) Program Requirements
Federal Register pages 518-536

Proposal Summary: For the CY16 payment determination and subsequent years, CMS proposes to adopt the following four measures for the ASCQR Program.

Background: In the CY12 OPPS/ASC final rule with comment period, CMS finalized its proposal to implement the ASCQR Program beginning with the CY14 payment determination; adopted quality measures for the CY14, CY15, and CY16 payment determinations and subsequent years; and finalized some data collection and reporting timeframes for these measures. CMS also adopted policies with respect to the maintenance of technical specifications and the updating of measures, publication of ASCQR Program data, and, for the CY14 payment determination, data collection and submission requirements for the claims-based measures.
See *Appendix for table containing CY14 and CY15 Hospital OQR Program Measures.*

CMS's Proposal: In the CY12 OPPS/ASC final rule with comment period, in an effort to streamline the rulemaking process, CMS finalized its policy that, when it adopts measures for the ASCQR Program, these measures are automatically adopted for all subsequent years payment determinations unless it proposes to remove, suspend, or replace the measures.

ASCQR Program Quality Measures

The quality measures that CMS has previously adopted are listed below:

- ASC-1: Patient Burn
- ASC-2: Patient Fall
- ASC-3: Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant
- ASC-4: Hospital Transfer/Admission*
- ASC-5: Prophylactic Intravenous (IV) Antibiotic Timing
- ASC-6: Safe Surgery Checklist Use
- ASC-7: ASC Facility Volume Data on Selected ASC Surgical Procedure
- ASC-8: ASC- 8: Influenza Vaccination Coverage among Healthcare Personnel

Procedure categories and corresponding HCPCS codes are located at:
http://qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=12

Additional ASCQR Program Quality Measures for CY16 Payment Determination and Subsequent Years

CMS is proposing quality measures for the CY16 payment determination and subsequent years (See Appendix 2 for a table containing these proposed OQR Program measures) based on its approach for future measure selection and development finalized in the CY13 OPPS/ASC final rule with comment period, which includes, among other considerations, aligning the ASCQR Program measures with its efforts in other clinical care settings and taking into account the views of the Measure Application Partnership (MAP). CMS believes that ASCs and HOPDs are similar in their delivery of surgical and related nonsurgical services. Therefore, it seeks to propose quality measures that can be applied to both HOPDs and ASCs to the extent possible because many of the same surgical procedures are performed in both of these settings.

For the CY16 payment determination and subsequent years, CMS proposes to adopt the following four measures for the ASCQR Program, all of which were reviewed by the MAP and three of which are NQF-endorsed for the ASC setting:

- Complications within 30 days following cataract surgery requiring additional surgical procedures (0564)
- Endoscopy/poly surveillance: appropriate follow-up interval for normal colonoscopy in average risk patients (NQF #0658)
- Endoscopy/poly surveillance: colonoscopy interval for patients with a history of adenomatous polyps –avoidance of inappropriate use (NQF #0659)
- Cataracts: improvement in patient's visual function within 90 days following cataract surgery (NQF #1536)

Data collection for these four measures would begin in CY14, and aggregate data (numerators, denominators, and exclusions) on all ASC patients for these four proposed chart-abstracted measures would be collected via an online web-based tool that would be made available to ASCs via the QualityNet web site.

ASCQR Program Measure Topics for Future Consideration

CMS seeks to develop a comprehensive set of quality measures to be available for widespread use for informed decision-making and quality improvement in the ASC setting. Through future rulemaking, we intend to propose new measures that address clinical quality of care, patient safety, care coordination, patient experience of care, surgical outcomes, surgical complications, complications of anesthesia, and patient reported outcomes of care.

Payment Reduction for ASCs that Fail to Meet the ASCQR Program Requirements

Under the ASCQR Program, any annual update would be reduced by 2.0 percentage points for ASCs that fail to meet the reporting requirements of the ASCQR Program. This reduction would apply beginning with the CY14 payment rates. In the CY13 OPPS/ASC final rule with comment period, in order to implement the requirement to reduce the annual update for ASCs that fail to meet the ASCQR Program requirements, CMS finalized its proposal that it would calculate two conversion factors: a full update conversion factor and an ASCQR Program reduced update conversion factor. CMS finalized its proposal that application of the 2.0 percent reduction to the annual update may result in the update to the ASC payment system being less than zero prior to the application of the MFP adjustment. For ASCs that receive the reduced ASC payment for failure to meet the ASCQR Program requirements, CMS believes that it is both equitable and appropriate that a reduction in the payment for a service should result in proportionately reduced copayment liability for beneficiaries. Therefore, the Medicare beneficiary's national unadjusted copayment for a service to which a reduced national unadjusted payment rate applies would be based on the reduced national unadjusted payment rate.

Collection Periods for Measures for the CY14 Payment Determination and Subsequent Years

In the FY13 IPPS/LTCH PPS final rule, CMS adopted a policy that claims for services furnished between October 1, 2012, and December 31, 2012, would have to be paid by the administrative contractor by April 30, 2013, to be included in the data used for the CY14 payment determination. For the CY15 payment determination and subsequent years, an ASC must submit complete data on individual claims-based quality measures through a claims-based reporting mechanism by submitting the appropriate quality data codes (QDCs) on the ASC's Medicare claims. The data collection period for such claims-based quality measures is the calendar year 2 years prior to a payment determination year.

The claims for services furnished in each calendar year have to be paid by the administrative contractor by April 30 of the following year of the ending data collection time period to be included in the data used for the payment determination year. Therefore, for the CY15 payment determination, the data collection period is claims for services furnished in CY13 (January 1, 2013 through December 31, 2013) which are paid by the administrative contractor by April 30, 2014. For the CY16 payment determination, the data collection time period for these measures would be calendar year 2014 (January 1, 2014, to December 31, 2014) and the data submission time period would be January 1, 2015, to August 15, 2015. CMS is proposing these changes to increase the timeframe for allowing data submission for these measures and to align the data collection time periods for the claims-based and web-based measures.

Appendix 1- CY14 and CY15 Hospital OQR Program Measures

Hospital OQR Program Measures for the CY 2014 and CY 2015 Payment Determinations and Subsequent Years	
NQF#	Measure Name
0287	OP-1: Median Time to Fibrinolysis
0288	OP-2: Fibrinolytic Therapy Received Within 30 Minutes
0290	OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention
0286	OP-4: Aspirin at Arrival
0289	OP-5: Median Time to ECG
0270	OP-6: Timing of Antibiotic Prophylaxis
0268	OP-7: Prophylactic Antibiotic Selection for Surgical Patients
0514	OP-8: MRI Lumbar Spine for Low Back Pain
--	OP-9: Mammography Follow-up Rates
--	OP-10: Abdomen CT – Use of Contrast Material
0513	OP-11: Thorax CT – Use of Contrast Material
0489	OP-12: The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their ONC-Certified EHR System as Discrete Searchable Data
0669	OP-13: Cardiac Imaging for Preoperative Risk Assessment for Non Cardiac Low Risk Surgery
--	OP-14: Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT)
--	OP-15: Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache*
0491	OP-17: Tracking Clinical Results between Visits
0496	OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients
0649	OP-19: Transition Record with Specified Elements Received by Discharged ED Patients

Appendix 1 cont. – CY14 and CY15 Hospital OQR Program Measures

Hospital OQR Program Measures for the CY 2014 and CY 2015 Payment Determinations and Subsequent Years	
--	OP-20: Door to Diagnostic Evaluation by a Qualified Medical Professional
0662	OP-21: Median Time to Pain Management for Long Bone Fracture
--	OP-22: ED- Patient Left Without Being Seen
0661	OP-23: ED- Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT or MRI Scan Interpretation Within 45 minutes of Arrival
0643	OP-24: Cardiac Rehabilitation Patient Referral From an Outpatient Setting
--	OP-25: Safe Surgery Checklist Use
--	OP-26: Hospital Outpatient Volume on Selected Outpatient Surgical Procedures**

Appendix 2 - Proposed 2016 and Subsequent Years Hospital OQR Program Measures

Proposed Hospital OQR Program Measure Set for the CY 2016 Payment Determination and Subsequent Years	
NQF#	Measure Name
0287	OP-1: Median Time to Fibrinolysis
0288	OP-2: Fibrinolytic Therapy Received Within 30 Minutes
0290	OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention
0286	OP-4: Aspirin at Arrival
0289	OP-5: Median Time to ECG
0270	OP-6: Timing of Antibiotic Prophylaxis
0268	OP-7: Prophylactic Antibiotic Selection for Surgical Patients
0514	OP-8: MRI Lumbar Spine for Low Back Pain
--	OP-9: Mammography Follow-up Rates
--	OP-10: Abdomen CT – Use of Contrast Material
0513	OP-11: Thorax CT – Use of Contrast Material
0489	OP-12: The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their ONC-Certified EHR System as Discrete Searchable Data
0669	OP-13: Cardiac Imaging for Preoperative Risk Assessment for Non Cardiac Low Risk Surgery
--	OP-14: Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT)
--	OP-15: Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache*
0491	OP-17: Tracking Clinical Results between Visits
0496	OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients
--	OP-20: Door to Diagnostic Evaluation by a Qualified Medical Professional

Appendix 2 cont. - Proposed 2016 and Subsequent Years Hospital OQR Program Measures

0662	OP-21: Median Time to Pain Management for Long Bone Fracture
--	OP-22: ED- Patient Left Without Being Seen
0661	OP-23: ED- Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT or MRI Scan Interpretation Within 45 minutes of Arrival
--	OP-25: Safe Surgery Checklist Use
--	OP-26: Hospital Outpatient Volume on Selected Outpatient Surgical Procedures**
0431	OP-27: Influenza Vaccination Coverage among Healthcare Personnel***
0564	OP-28: Complications within 30 days Following Cataract Surgery Requiring Additional Surgical Procedures***
0658	OP-29: Endoscopy/Poly Surveillance: Appropriate follow-up interval for normal colonoscopy in average risk patients***
0659	OP-30: Endoscopy/Poly Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use***
1536	OP-31: Cataracts – Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery***