



hfma

healthcare financial management association

CY14 OPPS Final Rule Fact Sheet

Submission of Comments

This document provides an overview of the Medicare final rule for the Outpatient Prospective Payment System (OPPS) for calendar year 2014 (CY14). The final rule with comment period is available in the December 10, 2014, [Federal Register](#).

The final rule is effective **January 1, 2014**.

CMS must receive comments on the final rule by 5 p.m. EST on January 27, 2014. When commenting, please refer to file code CMS-1601-FC.

Because of staff and resource limitations, CMS cannot accept comments by fax.

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-FC
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-FC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Overview

The Centers for Medicare & Medicaid Services (CMS) released a final rule which 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 in calendar year 2014 (CY14). 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.

Payment Impact

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 75180-75184 of the final rule.

CY14 OPPS Update Impact Table

	All Changes (Percentage)
All Hospitals	1.9
Urban Hospitals	2.0
Rural Hospitals	1.1
Teaching Status	
Non-Teaching	1.8
Minor	2.3
Major	1.4

OPPS Payment Updates

Federal Register, pages 75176 & 74949

Final Update: For FY14, CMS payment rates under the OPSS will increase by the final OPD fee schedule increase factor of **1.7 percent** for those hospitals that submit quality data, and -0.2 percent for those that do not.

Background: The estimated increase in the total payments made under the OPSS 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.

Update Summary: The final 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 **0.5** percent for FY14 (also the final MFP adjustment for FY14 in the FY14 IPPS/LTCH PPS final 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 final OPD fee schedule increase factor of **1.7** percent, which CMS will use in the calculation of the final 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 will 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 will receive an OPD fee schedule increase factor of **-0.3** percent (which is 2.5 percent, the final estimate of the hospital inpatient market basket percentage increase, less the proposed 0.5 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 final 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 Final Payment Increase
2.5	0.5	0.3	1.7

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	0.5	0.3	2.0	-0.3

Conversion Factor Update

Federal Register, pages 74949-74950

Final Update: The final conversion factor for CY14 is **\$72.728**. To set the OPPS conversion factor for CY14, CMS will increase the CY13 conversion factor of \$71.313 by 1.7 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.

Update Summary: To set the OPPS conversion factor for CY14, CMS is increasing the CY13 conversion factor of \$71.313 by 1.7 percent. In accordance with section 1833(t)(9)(B) of the Act, CMS will 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

will calculate an overall budget neutrality factor of **1.0002** for wage index changes by comparing proposed total estimated payments from its simulation model using the final FY14 IPPS wage indices to those payments using the (FY13) IPPS wage indices, as adopted on a calendar year basis for the OPSS. For CY14, CMS did not propose to make a change to its rural adjustment policy. Therefore, **the 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 will equal approximately \$12.3 million, which represents 0.02 percent of total projected CY14 OPSS spending. Therefore, the conversion factor is also 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 an adjustment for CY14 of 0.13 percent. Finally, estimated payments for outliers remain at 1.0 percent of total OPSS payments for CY14.

The final OPD fee schedule increase factor of 1.7 percent for CY14, the required wage index budget neutrality adjustment of approximately 1.0002, the cancer hospital payment adjustment of 1.0005, and the adjustment of 0.13 percent of projected OPSS spending for the difference in the pass-through spending result in a conversion factor for CY14 of **\$72.672.**

Hospitals that fail to meet the reporting requirements of the Hospital OQR Program will 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 OPSS payment rates made for their services. To calculate the 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 making all other adjustments discussed above, but using a reduced OPD fee schedule update factor of -0.3 percent. This results in a reduced conversion factor for CY14 of **\$71.219** for those hospitals that fail to meet the Hospital OQR requirements (a difference of -\$1.453 in the conversion factor relative to those hospitals that meet the Hospital OQR requirements).

Hospital Outpatient Outlier Payments

Federal Register, pages: 74958-74960

Final Update: The fixed-dollar threshold is **\$2,775** for FY14. The FY13 fixed dollar threshold was \$2,025.

Background: Currently, the OPSS 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 OPSS. The current estimate of total outlier payments as a percent of total CY12 OPSS payment, using available CY12 claims and the revised OPSS expenditure estimate for the 2013 Trustee's Report, is approximately 1.2 percent of the total aggregated OPSS payments. Therefore, for CY12, CMS estimates that it paid 0.2 percent above the CY12 outlier target of 1.0 percent of total aggregated OPSS payments. As explained in the CY13 OPSS/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 OPSS for CY13. The outlier thresholds were set so that estimated CY13

aggregate outlier payments would equal 1.0 percent of the total estimated aggregate payments under the OPSS. Using CY12 claims data and CY13 payment rates, CMS currently estimates that the aggregate outlier payments for CY13 will be approximately 1.1 percent of the total CY13 OPSS payments.

Update Summary: For CY14, CMS will apply the overall cost-to-charge ratios (CCRs) from the October 2013 OPSF with a CCR adjustment factor of 0.9645 to approximate CY14 CCRs to charges on the final CY12 claims that were adjusted to approximate CY14 charges (using the final 2-year charge inflation factor of 1.0969). These are the same CCR adjustment and charge inflation factors that were used to set the IPSS fixed dollar threshold for the FY14 IPSS/LTCH PPS final rule. CMS simulated aggregated CY14 hospital outlier payments using these costs for several different fixed-dollar thresholds, holding the 1.75 multiple threshold constant and assuming that outlier payment 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 OPSS payments. CMS estimates that a fixed-dollar threshold of \$2,900, combined with the multiple threshold of 1.75 times the APC payment rate, will allocate 1.0 percent of estimated aggregated total OPSS payments to outlier payments.

For CY14, CMS will 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 final fixed-dollar threshold of \$2,900 are met. If a community mental health center's (CMHC's) cost for partial hospitalization services, paid under either APC 0172 or APC 0173, exceeds 3.40 times the payment rate for APC 0173, the outlier payment is calculated as 50 percent of the amount by which the cost exceeds 3.40 times the APC 0173 payment rate. CMS estimates that this threshold will allocate 0.16 percent of outlier payments to CMHCs for partial hospitalization program (PHP) outlier payments.

Wage Index Changes

Federal Register, pages 74950-74952

Final Update: For the CY14 OPSS, frontier state hospitals will 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 OPSS payment rate is called the OPSS labor-related share. The OPSS labor-related share is 60 percent of the national OPSS 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 OPSS were attributable to wage costs.

CMS is adopting the FY14 IPPS wage index for the CY14 OPSS in its entirety, including the rural floor, geographic reclassifications, and all other wage index adjustments.

CMS continues to believe that using the IPPS wage index as the source of an adjustment factor for the OPSS is reasonable and logical, given the inseparable, subordinate status of the hospital outpatient department (HOPD) within the hospital overall. Therefore, CMS did not propose to change its current regulations, which require that it use the FY14 IPPS wage indices for calculating OPSS payments in CY14. CMS is not reprinting the final FY14 IPPS wage indices referenced in its discussion of the wage index.

Readers are referred to the CMS website for the OPSS at:
<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html>.

At this site, readers will find a link to the final FY14 IPPS wage index tables.

Update Summary: 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 OPSS final rule with comment period. Therefore, it did not propose to revise this policy for the CY14 OPSS. *CMS refers readers to section II.H. of the final 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 OPSS, frontier state hospitals will 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. Similar to its current policy for HOPDs that are affiliated with multicampus hospital systems, the HOPD will receive a wage index based on the geographic location of the specific inpatient hospital with which it is associated.

CMS will continue its policy for CY14 of allowing non-IPPS hospitals paid under the OPSS to qualify for the out-migration adjustment if they are located in a section 505 out-migration county. CMS refers readers to the CMS website for the OPSS 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 74832, 74955-74956

Final Update: CMS is continuing the adjustment of 7.1 percent to the OPSS payments to certain rural sole community hospitals (SCHs), including essential access community hospitals (EACHs). This adjustment will apply to all services paid under the OPSS, excluding separately payable drugs and biologicals, devices paid under the pass-through payment policy, and items paid at charges reduced to cost.

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 outlier payments and copayments.

Cancer Hospital Payment Adjustment

Federal Register, pages 74832, 74956-74958

Final Update: Additional payments to cancer hospitals will result in a final target payment-to-cost ratio (PCR) equal to 0.89.

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.

Update Summary: CMS is finalizing its proposal 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 were available at the time of this final rule. To calculate the final CY14 target PCR, CMS used the same extract of cost report data from HCRIS, as discussed in section II.A. of the final rule, used to estimate costs for the CY14 OPPS. Using these cost report data, CMS included data from Worksheet E, Part B, for each hospital, using data from each hospital's most recent cost report, whether as submitted or settled.

Using a smaller dataset of cost report data, CMS estimated that, on average, the OPPS payments to other hospitals furnishing services under the OPPS are approximately 89 percent of reasonable cost (weighted average PCR of 0.89). Based on these data, CMS used a target PCR of 0.89 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 will be the additional payment needed to result in a PCR equal to 0.89 for each cancer hospital. Table 17 of the final rule indicates the estimated percentage increase in OPPS payments to each cancer hospital for CY14 due to the cancer hospital payment adjustment policy. The actual amount of the CY14 cancer hospital payment adjustment for each cancer hospital will be determined at cost report settlement and will depend on each hospital's CY14 payments and costs.

CMS notes that the changes made by section 1833(t)(18) of the Act do not affect the existing statutory provisions that provide for transitional outpatient payments (TOPs) for cancer hospitals. These payments will be assessed as usual after all payments, including the cancer hospital payment adjustment, have been made for a cost reporting period.

Packaged Services

Federal Register, pages 74832, 74925-74947

Background: The OPSS packages payment for multiple interrelated items and services into a single payment to create incentives for hospitals to furnish services most efficiently and to manage their resources with maximum flexibility.

Update Summary: Beginning in CY14, CMS is unconditionally or conditionally packaging the following five categories of items and services, and adding them to the list of OPSS packaged items and services:

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

CMS believes that each of the above unconditionally or conditionally packaged categories of items or services is appropriate according to existing packaging policies or expansions of existing packaging policies. CMS is finalizing its proposal to unconditionally package procedures described by add-on codes, with the exception of add-on codes for drug administration services and for CY14 add-on codes assigned to device-dependent APCs. In addition, for CY14 only, CMS will continue to separately pay for procedures described by add-on codes that are currently assigned to device-dependent APCs. CMS is also revising § 419.2(b) to include add-on code procedures among the services that are packaged in the OPSS. The specific add-on codes that it is unconditionally packaging and assigning status indicator “N” for CY14 are listed in Addendum P and Addendum B to this final rule. The supporting documents for this final rule with comment period, including these addenda, are available at the CMS website at:

<http://www.cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html>.

CMS will not finalize its proposal to conditionally package codes currently assigned the ancillary service status indicator “X” for CY14 when performed with another service, with the exception that CPT code 93017 will be conditionally packaged. CMS may review the services assigned status indicator “X” (ancillary services) to determine which may be appropriate for packaging as ancillary services in the OPSS in future years. CMS is also not finalizing its proposal to conditionally package diagnostic tests on the bypass list for CY14, or its proposal to assign these codes a status indicator of “Q1.” However, it is finalizing its policy to conditionally package device removal procedures in the OPSS when performed together with a repair or replacement of

a device and to assign a status indicator of “Q2.” The specific device removal procedure codes that CMS is conditionally packaging and assigning to status indicator “Q2” for CY14 are listed in Addendum P to the final rule, available on the CMS website.

Pass-through Payments for Devices

Federal Register, pages 75003-75005

Background: Section 1833(t)(6)(B)(iii) of the Act requires that, under the OPSS, 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 OPSS annual update.

Update Summary

Expiration of Transitional Pass-Through Payments for Certain Devices

There are currently three device categories eligible for pass-through payment: HCPCS codes C1830 (Powered bone marrow biopsy needle) and C1840 (Lens, intraocular (telescopic)), which are effective for pass-through payment as of October 1, 2011; and HCPCS code C1886 (Catheter, extravascular tissue ablation, any modality (insertable)), which is effective for pass-through payment as of January 1, 2012. Recognizing that these three device categories were eligible for at least 2, but not more than 3, years of pass-through status, in the CY13 OPSS/ASC final rule with comment period, CMS finalized the expiration of pass-through payment for all three of these HCPCS codes, which will expire after December 31, 2013. Therefore, in accordance with its established policy, after December 31, 2013, CMS will package the respective costs of the HCPCS codes C1830, C1840, and C1886 devices into the costs of the procedures with which the devices are reported in the hospital claims data used in OPSS ratesetting.

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

CMS finalized, without modification, the updated 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 website 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. In addition, CMS will update on the website 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 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.

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

For CY14, CMS will modify its existing policy of reducing OPSS payment for specified APCs when a hospital furnishes a specified device without cost or with a full or partial credit. Specifically, CMS will require hospitals 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 31 of the final rule with comment period that is 50 percent or greater than the cost of the device. CMS will also limit the OPSS payment deduction for the applicable APCs listed in Table 30 of the final rule to the total amount of the device offset when the “FD” value code appears on a claim.

CMS examined the offset amounts calculated from the CY14 final rule data and the clinical characteristics of the final CY14 APCs to determine which APCs meet the criteria for CY14. Based on the CY12 claims data available for the final rule with comment period, CMS is not making any changes to the proposed lists of APCs and devices to which this modified policy applies.

Payments for Hospital Outpatient Visits

Federal Register, pages 75036-75043

Final Update: CMS will create a new alphanumeric HCPCS code, G0463 (Hospital outpatient clinic visit for assessment and management of a patient), for hospital use only representing any clinic visit under the OPSS and assign new HCPCS code G0463 to new APC 0634.

Background: Currently, hospitals report HCPCS visit codes to describe three types of OPSS 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 41 of the final rule.

Update Summary: CMS will create a new alphanumeric HCPCS code, G0463 (Hospital outpatient clinic visit for assessment and management of a patient), for hospital use only representing any clinic visit under the OPSS and also assign new HCPCS code G0463 to new APC 0634. CMS will also use CY12 claims data to develop CY14 OPSS payment rates for the new HCPCS code G0463 based on the total geometric mean cost of the levels one through five CPT E/M codes for clinic visits currently recognized under the OPSS (CPT codes 99201 through 99205 and 99211 through 99215). Additionally, CMS will no longer recognize a distinction between new and established patient clinic visits.

For CY14, CMS is not finalizing its proposal for CY14 to discontinue its longstanding policy of recognizing five distinct visit levels for Type A ED visits and to create a new alphanumeric HCPCS G-code for hospital use only representing any Type A ED visit under the OPSS. Similarly, it is also not finalizing its proposal to discontinue its longstanding policy of recognizing five distinct visit levels for Type B ED visits and to create a new alphanumeric HCPCS G-code for hospital use only representing any Type B ED visit under the OPSS.

Also, CMS will not assign the newly created alphanumeric Type A ED visit HCPCS G-code to its own newly created APC 0635, nor will it assign the newly created alphanumeric Type B ED visit HCPCS G-code to its own newly created APC 0636. Instead, it will continue to its existing methodology to recognize the existing CPT codes for Type A ED visits as well as the five HCPCS codes that apply to Type B ED visits, and establish the CY 2014 OPPS payment under our established standard process. These codes and their APC assignments for CY13 compared to their APC assignments for CY14 are listed in Table 42 of the final rule.

CMS intends to further explore the issues related to ED visits, for example, concerns about excessively costly patients, such as trauma patients, and potential alternatives that commenters provided to address this issue. CMS notes that it may propose changes to the coding and APC assignments for ED visits in future rulemaking.

Partial Hospitalization Payments APC Update

Federal Register, pages 75045-75053

Final Update: Level I PHP will increase from approximately \$87 to approximately \$95 for CY14, and the proposed geometric mean per diem costs for Level II PHP services will 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 approximately \$87 to approximately 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.*

Update Summary: For CY14, CMS applied 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 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 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.

The CY14 geometric mean per diem costs for the PHP APCs are shown below (Tables 43 and 44 of the final rule).

APC	Group Title	Proposed Geometric Mean Per Diem Costs
0172	Level I Partial Hospitalization (3 services) for CMHCs	\$99.39
0173	Level II Partial Hospitalization (4 or more services) for CMHCs	\$112.12

APC	Group Title	Proposed Geometric Mean Per Diem Costs
0175	Level I Partial Hospitalization (3 services) for hospital-based PHPs	\$190.82
0176	Level II Partial Hospitalization (4 or more services) for hospital-based PHPs	\$214.39

CMHCs and hospital-based PHPs continue to show significant differences in their costs. As CMS explained in the CY12 OPSS/ASC final rule with comment period, it attributed the decrease in costs to CMHCs having a lower cost structure than hospital-based PHP providers, in part, because the data showed (and continue to show) that CMHCs provide fewer PHP services in a day and use less costly staff than hospital-based PHPs. In other words, hospital-based providers have traditionally provided more services than CMHCs during a PHP day. Providing fewer services during a PHP day results in less overhead expense for the provider; that is, less time the provider needs to pay staff, less time the provider needs to heat the building, and less time the provider needs to light the building. Therefore, providing fewer PHP services during a day directly contributes to a lower overall cost structure. In light of these differences in cost structures between provider types, it is inappropriate to treat CMHCs and hospital-based PHP providers in the same manner.

CMS understands the concerns raised by the commenters regarding the differences between CMHC PHP APC per diem payment rates and hospital-based PHP APC per diem payment rates, and CMS continues to believe that it is important to calculate PHP APC per diem payment rates based on the data for each type of provider in order to appropriately pay for PHP services. CMS also believes that the CMHC and the hospital-based PHP APC per diem payment rates accurately reflect the claims and cost report data of CMHCs and hospital-based providers, respectively. The PHP APC per diem payment rates are directly related to the accuracy of the claims and cost report data submitted by providers. Therefore, it is imperative that providers submit accurate claims and cost reports in order for the payment rates to most accurately reflect the costs to providers. The resulting PHP APC per diem payment rates reflect the cost of what providers expend to maintain such programs.

In the CY14 OPSS proposed rule, CMS noted that it was 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. It did not propose new Medicare policy in the discussion of possible future modifications, but requested public comments on possible future initiatives. CMS received a wide range of comments from health and behavioral healthcare associations, hospitals, providers and professionals interested in future initiatives related to partial hospitalization services, and will take them into consideration for further rulemaking to strengthen the PHP benefit and payment structure.

OPPS Payment Status and Comment Indicators

Federal Register, pages 75062-75064

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

The complete list of the CY14 status indicators and their definitions is displayed in Addendum D1 on the CMS website at: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html>

The CY14 status indicator assignments for APCs and HCPCS codes are shown in Addendum A and Addendum B, respectively, on the CMS website at: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html>

Update Summary

CY14 Payment Status Indicator Definitions

For CY14, CMS will 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. New status indicator “J1” is finalized with delayed effective date of CY15. The comprehensive APCs that CMS established are described in detail in section II.A.2.e. of the final rule. For CY14, CMS is not finalizing its 2014 proposal to package ancillary services. Therefore, it will not be deleting status indicator “X” for CY14.

CMS will revise the definitions of status indicators “S” and “T” to remove the word “significant” from these definitions; and to add the word “service” to the definition of status indicator “S” to indicate “procedure or service; not discounted when multiple” and to status indicator “T” to indicate “procedure or service; multiple reduction applies.” CMS believes that these revisions better describe the entire range of procedures and services that will be assigned these status indicators for CY14. CMS will also remove “Routine Dialysis Services for ESRD 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 OPSS 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 OPSS, CMS will use the same two comment indicators that are in effect for the CY13 OPSS:

- “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 has no operational need to create additional comment indicators that are specific to various types of changes. Therefore, it believes that the CY13 definitions of the OPSS comment indicators continue to be appropriate for CY14 and we are continuing to use those definitions without modification for CY14. The final definitions of the OPSS status indicators are listed in Addendum D2 on the CMS website at: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html>.

Comprehensive APCs

Federal Register, pages 74832-74869

Final Update: In order to improve the accuracy and transparency of its payment for certain device-dependent services, CMS is finalizing its policy to establish 29 comprehensive APCs to prospectively pay for the most costly hospital outpatient device-dependent services, but it is delaying implementation of this policy until CY15.

Background: CMS defines a comprehensive APC as a classification for the provision of a primary service and all adjunct services provided to support the delivery of the primary service. For services that trigger a comprehensive APC payment, the comprehensive APC will treat all individually reported codes on the claim as representing components of the comprehensive service, resulting in a single prospective payment based on the cost of all individually reported codes on the claim.

Update Summary: CMS will make a single payment for the comprehensive service based on all charges on the claim, excluding only charges for services that cannot be covered by Medicare Part B or that are not payable under the OPSS. CMS has also modified its methodology to make larger payments for many complex and costly multiple device procedures. Due to its decision to delay implementation until CY15 for operational reasons, CMS invites comments on this section of the final rule. CMS has published tables in the rule to demonstrate how this policy would have been implemented in CY14, and will be considering comments as it updates the policy for CY15

to account for changes that may occur in the CY13 claims data. Table 8 of the final rule contains the APCs for which CMS is finalizing this proposal for CY15.

Application of Therapy Caps in CAHs

Federal Register, pages 75057-75058

Final Update: CMS will continue the methodology required by the American Taxpayer Relief Act of 2012 (ATRA), which requires 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. After consideration of all of the public comments received in the CY14 MPFS final rule, CMS is finalizing its proposal to apply the therapy caps and related provisions to services furnished by a CAH beginning on January 1, 2014. CMS is including in the final rule a reference to the final policy as an additional means to direct CAHs' attention to its policies in the CY14 MPFS final rule.

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."

Update Summary: 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 proposed 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 proposed 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. After consideration of all of the public comments received in the CY14 MPFS final rule, CMS finalizes its proposal to apply the therapy caps and related provisions to services furnished by a CAH beginning on January 1, 2014. CMS also included in the CY14 OPFS final rule a reference to the final policy as an additional means to direct CAHs' attention to its policies in the CY14 MPFS final rule.

Hospital OQR Program Updates

Federal Register, pages 75090-75120

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.

Update Summary: CMS is finalizing the removal of the following measures, *with the clarification that removal applies for the CY15 payment determination and subsequent years.*

- *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 that CMS previously adopted and retained for the CY14 and CY15 payment determination and subsequent years under the Hospital OQR Program can be found in Appendix 1. The table also includes OP-19 and OP-24, with a notation that CMS is removing these two measures for the CY15 payment determination and subsequent years.

Quality Measures for the CY16 Payment Determination and Subsequent Years

CMS is adopting the following four new measures for the Hospital OQR Program for the CY16 payment determination and subsequent years, including one CDC/NHSN measure, and three 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

- Endoscopy/polyp 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)

All of the final 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 these measures are services commonly provided to patients who visit HOPDs and, for this

reason, CMS believes that these measures are appropriate for the measurement of quality of care furnished by hospitals in outpatient settings.

CMS has finalized the three measures that are chart-abstracted with aggregate data submission via the web-based tool that will be made available to HOPDs via the QualityNet website. This web-based tool is currently in use in the Hospital OQR Program to collect structural measure information. CMS believes that chart-abstracted measure data collected in aggregate form is currently the most appropriate collection method, and is finalizing the aggregate mode of data collection for the three new chart-abstracted measures in section XIII.H.2.f. of the final rule

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

Possible Hospital OQR Program Measure Topics for Future Consideration

The current measure set for the Hospital OQR Program includes measures that assess process of care, imaging efficiency patterns, care transitions, ED throughput efficiency, the use of Health Information Technology (HIT) care coordination, patient safety, and volume. CMS anticipates that as electronic health record (EHR) technology evolves and more infrastructure is put into place, it will have the capacity to accept electronic reporting of many clinical chart-abstracted measures that are currently part of the Hospital OQR Program using certified EHR technology. CMS is working diligently toward this goal. CMS believes that this progress, at a near future date, would significantly reduce the administrative burden on hospitals under the Hospital OQR Program to report chart abstracted measures.

Reporting Ratio Application and Associated Adjustment Policy for CY14

CMS will apply the Hospital OQR Program reduction with modification to reflect the CY14 OPSS status indicators to which the adjustment would apply. As a result, for the CY14 OPSS, CMS is applying a reporting ratio of 0.980 to the national unadjusted payments, minimum unadjusted copayments, and national unadjusted copayments for all applicable services for those hospitals failing to meet the Hospital OQR Program reporting requirements. This reporting ratio applies to HCPCS codes assigned status indicators “P,” “Q1,” “Q2,” “Q3,” “R,” “S,” “T,” “U,” “V,” or “X” excluding services paid under new technology APCs. All other applicable standard adjustments to the OPSS national unadjusted payment rates for hospitals that fail to meet the requirements of the Hospital OQR Program will continue to apply. CMS will continue to calculate OPSS outlier eligibility and outlier payment based on the reduced rates for those hospitals that fail to meet the reporting requirements.

CMS would also continue to apply all other applicable standard adjustments to the OPSS national unadjusted payment rates for hospitals that fail to meet the requirements of the Hospital OQR Program. Similarly, it would continue to calculate OPSS 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 75120-75122

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.

Update Summary:

Additional CMS Appeals Review Process

CMS is finalizing the proposal 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. A hospital will 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 requiring 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 will 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

In the FY14 IPPS/LTCH PPS final rule, CMS adopted the CLABSI, CAUTI, and SSI measures, which are reported to CDC’s NHSN, for the FY16 Hospital VBP Program. However, when it proposed to adopt these measures in the FY14 IPPS/LTCH PPS proposed rule, it inadvertently did not make FY16 performance and baseline period proposals for these proposed measures. In the CY14 OPPI/ASC proposed rule, CMS proposed to adopt FY16 performance and baseline periods for these measures so that it would have enough time to consider and respond to public comments before the proposed start of the performance periods.

After consideration of the public comments received, CMS is finalizing the FY16 performance and baseline periods for the CAUTI, CLABSI, and SSI measures as proposed. The finalized performance and baseline periods for the CAUTI, CLABSI, and SSI measures for the FY16 Hospital VBP Program appear in the following table:

Finalized Performance and Baseline Periods for CAUTI/CLABSI/SSI under the FY16 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 75056- 75057

Final Update: All outpatient therapeutic services furnished in hospitals and CAHs will 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 OPPTS/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 CY2000 OPPTS final rule with comment period.

Update Summary: CMS will not extend the enforcement instruction another year for CY14. The enforcement instruction will expire December 31, 2013.

Revisions of the Quality Improvement Organization (QIO) Regulations

Federal Register, pages 75144-75194

Final Update: CMS is updating the regulations at 42 CFR Parts 475 and 476 based on the recently enacted Trade Adjustment Assistance Extension Act of 2011 (TAAEA), whereby Congress authorized numerous changes to the original legislation and included additional flexibility for the Secretary in the administration of the QIO program.

Background: The existing regulations at 42 CFR Part 475 include definitions and standards governing eligibility and the award of contracts to QIOs. Section 261 of the TAAEA eliminated certain limitations specified in sections 1152 and 1153 of the Act that appear in several existing provisions in Part 475. In order to eliminate these limitations in the regulations and fully utilize the flexibility provided as a result of the statutory changes, in the CY14 OPPTS/ASC proposed rule, CMS proposed regulatory changes to implement the statutory amendments.

Update Summary: CMS is finalizing the partial deletion and revision of the regulations under 42 CFR Parts 475 and 476, which relate to the QIO program, including the following:

1. Replace nomenclature in Parts 475 and 476 that has been amended by the TAAEA
2. Revise the existing definition for the term “physician”
3. Add new definitions as necessary to support the new substantive provisions in Subpart C
4. Revise, add, and replace some of the substantive provisions in Subpart C in their entirety to fully exercise the Secretary’s authority for the program and update the contracting requirements to align with contemporary quality improvement

II. AMBULATORY SURGICAL CENTERS (ASCs)

Calculation of the ASC Payment Rates

Federal Register, pages 75087- 75089, 74833

Final Update: The final ASC conversion factor is **\$43.471** for ASCs that meet the quality reporting requirements and **\$42.612** for those that do not. The CY13 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.

Update Summary: CMS will apply its established methodology for determining the final CY14 ASC conversion factor. Using more complete CY12 data for the final rule with comment period than was available for the proposed rule, CMS calculated a wage index budget neutrality adjustment of 1.0009. Based on IHS Global Insight, Inc.'s 2013 third quarter forecast, the CPI-U for the 12-month period ending with the midpoint of CY14 is now projected to be 1.7 percent, while the MFP adjustment (using the revised IGI series to proxy the labor index used in the MFP forecast calculation as discussed and finalized in the CY12 MPFS final rule with comment period) is 0.5 percent, resulting in an MFP-adjusted CPI-U update factor of 1.2 percent for ASCs that meet the quality reporting requirements.

The final ASC conversion factor of \$43.471 for ASCs that meet the quality reporting requirements is the product of the CY13 conversion factor of \$42.917 multiplied by the wage index budget neutrality adjustment of 1.0009, and the MFP-adjusted CPI-U payment update of 1.2 percent.

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

CPI-U update	(Minus) MFP Adjustment	MFP-Adjusted CPI-U Update
1.7%	0.5%	1.2%

For ASCs that do not meet the quality reporting requirements, CMS is reducing the CPI-U update of 1.7 percent by 2.0 percent, and then applying the 0.5 percent MFP reduction, resulting in a **-0.8 percent** quality reporting/MFP-adjusted CPI-U update factor. The final ASC conversion factor of **\$42.612** for ASCs that do not meet the quality reporting requirements is the product of the CY13 conversion factor of \$42.917 multiplied by the wage index budget neutrality adjustment of 1.0009 and the quality reporting/MFP-adjusted CPI-U payment update of -0.8 percent.

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
1.7 %	2.0%	0.5%	-0.8 %

Based on this update, CMS estimates that total payments to ASCs (including beneficiary cost-sharing and estimated changes in enrollment, utilization, and case-mix) for CY14 will be approximately \$3.992 billion, an increase of approximately \$143 million compared to estimated CY13 payments.

Addenda AA and BB to the final rule (which are available via the internet on the CMS website) display the final updated ASC payment rates for CY14 for covered surgical procedures and covered ancillary services, respectively. The payment rates included in these addenda reflect the full ASC payment update and not the reduced payment update used to calculate payment rates for ASCs not meeting the quality reporting requirements under the ASCQR Program.

Payment for Covered Ancillary Services

Federal Register, pages 75122-75132

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 OPSS. Devices that are eligible for pass-through payment under the OPSS are separately paid under the ASC payment system. Currently, the four devices that are eligible for pass-through payment in the OPSS are described by HCPCS code C1830 (Powered bone marrow biopsy needle), HCPCS code C1840 (Lens, intraocular (telescopic)), HCPCS code C1841 (Retinal prosthesis, includes all internal and external components), and HCPCS code C1886 (Catheter, extravascular tissue ablation, any modality (insertable)). Payment amounts for HCPCS codes C1830, C1840, C1841, and C1886 under the ASC payment system are contractor priced. In the CY13 OPSS/ASC final rule with comment period, CMS finalized the expiration of pass-through payment for HCPCS codes C1830, C1840, and C1886, which will expire after December 31, 2013.

Update Summary: After December 31, 2013, the costs for devices described by HCPCS codes C1830, C1840, and C1886 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 OPSS relative payment weights that are used to establish ASC payment rates for CY14. HCPCS code C1841 was approved for pass-through payment effective October 1, 2013, and will continue to be eligible for pass-through payment in CY14.

Ambulatory Surgical Center Quality Reporting (ASCQR) Program Requirements
Federal Register, pages 75122-75141

Final Update: For the CY16 payment determination and subsequent years, CMS will adopt the following four measures for the ASCQR Program.

1. Influenza Vaccination Coverage among Healthcare Personnel
2. Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients
3. Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use
4. Cataracts – Improvement in Patient’s Visual Function within 90 Days Following Cataract Surgery

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, requirements for the claims-based measures.

See Appendix 1 for table containing CY14 and CY15 Hospital OQR Program Measures.

Update Summary: In the CY12 OPPS/ASC final rule, 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=OnetPublic%2FPage%2FOnetTier2&cid=12>

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

CMS adopted quality measures for the CY16 payment determination and subsequent years (see Appendix 2 for a table containing these final OQR Program measures) based on its approach for future measure selection and development finalized in the CY13 OPPTS/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 adopt 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.

CMS will adopt for the CY16 payment determination and subsequent years the same chart-abstracted measures for the Hospital OQR Program as are used for the ASQR Program for the CY16 payment determination and subsequent years:

- 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

CMS will collect aggregate data (numerators, denominators, and exclusions) on all ASC patients for these three finalized chart-abstracted measures via an online web-based tool that will be made available to ASCs via the QualityNet web site.

See Appendix 3 for the finalized measure set (a total of 11 measures) for the ASCQR Program for the CY16 payment determination and subsequent years.

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 decisionmaking and quality improvement in the ASC setting. Through future rulemaking, CMS intends 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. CMS has requested feedback from commenters, and will take the suggestions into consideration for future measure topics for the ASCQR Program.

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 percent 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 to 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.

In the CY13 OPPS/ASC final rule with comment period, CMS finalized a data collection and processing period for the CY15 payment determination and subsequent years. 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 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. Only claims for services furnished in each calendar year paid by the administrative contractor by April 30th of the following year of the ending data collection time period would be included in the data used for the payment determination year. Therefore, for example, only claims for services furnished in CY13 (January 1, 2013 through December 31, 2013) paid by the administrative contractor by April 30, 2014, would be included in the data used for the CY15 payment determination.

More Information

The final rule is available in the December 10, 2013, *Federal Register*. Additional information regarding the OPPS is available on the [Centers for Medicare and Medicaid Services \(CMS\) website](#).

Appendix 1- CY14 and CY15 Hospital OQR Program Measures

Hospital OQR Program Measures for the CY14 and CY15 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***
--	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

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-26: Hospital Outpatient Volume on Selected Outpatient Surgical Procedures**

* Public reporting for OP-15 continues to be deferred at the time of this CY14 OP/ASC proposed rule.

** OP-26 Procedure categories and corresponding HCPCS codes are located at:

http://qualitynet.org/dcs/BlobServer?blobkey=id&blobnocache=true&blobwhere=1228889963089&blobheader=multipart%2Foctet-stream&blobheadername1=Content-Disposition&blobheadervalue1=attachment%3Bfilename%3D1r_OP26MIF_v+6+0b.pdf&blobcol=urldata&blobtable=MungoBlobs

***In this final rule with comment period, CMS is removing OP-19 and OP-24 for the CY15 payment determination and subsequent years

Appendix 2 – Final 2016 and Subsequent Years Hospital OQR Program Measures

Finalized Hospital OQR Program Measure Set for the CY16 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
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***
0658	OP-29: Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for

Appendix 2 cont. – Final 2016 and Subsequent Years Hospital OQR Program Measures

Finalized Hospital OQR Program Measure Set for the CY 2016 Payment Determination and Subsequent Years	
NQF#	Measure Name
	Normal Colonoscopy in Average Risk Patients***
0659	OP-30: Endoscopy/Polyp 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***

* Public reporting for OP-15 continues to be deferred at the time of this CY14 OPPS/ASC final rule with comment period.

** OP-26: Procedure categories and corresponding HCPCS codes are located at:

http://qualitynet.org/dcs/BlobServer?blobkey=id&blobnocache=true&blobwhere=1228889963089&blobheader=multipart%2Foctet-stream&blobheadername1=Content-Disposition&blobheadervalue1=attachment%3Bfilename%3D1r_OP26MIF_v+6+0b.pdf&blobcol=urldata&blobtable=MungoBlobs.

*** New measures finalized for the CY16 payment determination and subsequent years.

Appendix 3 – ASC Program Measure Set for CY16 Payment Determination and Subsequent Years

ASC Program Measure Set for the CY16 Payment Determination and Subsequent Years	
	Measure Name
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 Procedures** Procedure categories and corresponding HCPCS codes are located at: http://qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772475754
ASC-8	Influenza Vaccination Coverage among Healthcare Personnel ***
ASC-9	Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients ***
ASC-10	Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps-Avoidance of Inappropriate Use***
ASC-11	Cataracts: Improvement in Patient’s Visual Function within 90 Days Following Cataract Surgery***

*New measure for the CY14 payment determination and subsequent years.

** New measure for the CY15 payment determination and subsequent years.

***New measure for the CY16 payment determination and subsequent years.