PUBLICATION

CMS Proposes Significant Changes and Clarifications in OPPS Proposed Rule [Ober|Kaler]

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In its OPPS proposed rule published July 19, 2013 [PDF], at Fed. Reg. 43534-43707, CMS proposed significant changes and clarifications to its current policy. Among the most notable changes are the four discussed below.

1. CMS Proposes Collapsing E&M Facility Codes

Currently hospitals report HCPCS visit codes to describe three types of OPPS services – clinic visits, emergency department (ED) visits (Type A and Type B ED visits) and critical care services – with 20 HCPCS codes assigned to clinic and ED visits. For calendar year 2014, CMS is proposing to collapse the number of codes to be reported for the hospital outpatient clinic and ED visits. Rather than recognizing five levels of clinic visits (5 for new patients and 5 for established patients) and ED visits (5 for Type A EDs and 5 for Type B EDs) respectively, CMS would create three new alphanumeric Level II HCPCS codes to describe all levels of clinic and ED visits. Thus, a single visit level for clinic visits, for Type A ED visits and for Type B ED visits would be recognized for payment. This approach, CMS maintains, is in line with its goal of using larger payment bundles. CMS, however, appears concerned that certain cases might not be best accommodated by use of a single payment. Accordingly, it has asked for comments on the extent to which its proposal should be changed, either to make exceptions for or to accommodate special cases or to determine if alternative policies would more accurately and appropriately pay for the visits.

2. Supervision of Hospital Outpatient Therapeutic Services for CAHs and Small Rural Hospitals

In its calendar year 2009 OPPS proposed and final rules, CMS articulated a policy under which direct supervision is required for most hospital outpatient therapeutic services. At the same time, CMS recognized that certain small rural hospitals and critical access hospitals (CAHs) would have difficulty satisfying the supervision standards, and it stated expressly that it would not enforce its supervision standards as they applied to those hospitals. This policy of non-enforcement has continued through 2013, but CMS now proposes to eliminate this nonenforcement policy as of the end of 2013.

3. CMS Proposes To Require That, As A Condition of Payment, Services Be Performed By Professionals Qualified To Do So Under Applicable State Law And Regulations

CMS proposes to amend the Medicare conditions of payment for hospital outpatient therapeutic services in a significant way. Under current policy, CMS generally defers to hospitals to ensure that state scope of practice and other rules are followed, which in turn, should result in hospital outpatient therapeutic services being performed only by qualified personnel. CMS has further stated in the past that it expected that hospitals would have credentialing procedures, by-laws, and other policies to ensure that hospital outpatient therapeutic

services are being provided only by qualified practitioners. CMS, however, has not specifically made compliance with state law a condition of payment for those services. And while complying with requirements of state law has long been a condition of participation, a violation of the participation conditions does not automatically result in an overpayment. As a result, Medicare has had limited recourse when outpatient therapeutic services have not been furnished in compliance with state law. To address this, CMS proposes to add a new condition of payment to its regulations, requiring that individuals who perform hospital or CAH outpatient therapeutic services do so in compliance with applicable laws and regulations, including licensure laws. By imposing this requirement, CMS will have a clear basis to deny Medicare payment when services are not furnished in accordance with these provisions.

4. Clarification of CMS Reopening Policy Regarding Predicate Facts

This spring, the United States Court of Appeals for the District of Columbia Circuit held that providers could appeal predicate facts used to determine their reimbursement in later fiscal periods even though those predicate facts were not timely appealed or reopened for periods when the facts first arose or were determined. *Kaiser Foundation Hospitals v. Sebelius*, 708 Fed. 3d 226 (D.C. Cir. 2013). In *Kaiser Foundation*, the predicate facts at issue were the teaching hospitals' FTE counts for their 1996 cost reporting period used to calculate their FTE caps for GME. The hospitals did not challenge the counts in 1996, nor in the first years when the cap were applied. Instead, they later appealed their caps in cost reporting periods beyond the 180 day appeal period and beyond the three year reopening period. The court allowed this, holding that CMS's reopening regulation permits modification of predicate facts in closed years provided the change will only affect the total reimbursement determination in open years.

In the 2014 OPPS proposed rule, CMS attempts to take on this court ruling by clarifying its policy through a revision to 42 C.F.R. § 405.1885. That clarification would specify that, absent a specific statute, regulation, or other legal provision permitting reauditing, revising or similar actions changing predicate facts: (1) the predicate fact is subject to change only through a timely appeal or reopening for the fiscal period in which the predicate fact first arose or the fiscal period for which such fact was first determined by the intermediary; and (2) the application of the predicate fact is subject to change only through a timely appeal and reopening of a cost report for the fiscal period in which it was first used (or applied) by the intermediary to determine the provider's reimbursement. CMS proposes that this revision be effective for any intermediary determination issued on or after the effective date of the final rule and for any appeal reopenings that are pending on or after the effective date of the final rule.

Ober|Kaler's Comments

These proposed provisions are significant and could have long-lasting impact on hospitals. Providers are encouraged to review the provisions carefully and to comment as appropriate.