AAOS
American Association of Orthopaedic Surgeons

CY 2022 Medicare Hospital Outpatient Prospective Payment System Proposed Rule: What Orthopaedic Surgeons Need to Know

The Calendar Year (CY) 2022 Medicare Hospital Outpatient Prospective Payment System (OPPS) proposed rule was released on July 19, 2021 by the Centers for Medicare & Medicaid Services (CMS). The annual payment rule sets policy for hospital outpatient departments and ambulatory surgical centers participating in the Medicare program and makes updates to the Hospital Outpatient Quality Payment Program. AAOS will submit formal comments to CMS and appreciates feedback from members ahead of the September 19, 2021 deadline. Then the final rule will likely be released in November, and the majority of the regulations will take effect on January 1, 2022.

Reversal of the Elimination of the Medicare Inpatient Only (IPO) List

CMS is proposing to halt the elimination of the Medicare Inpatient Only List that was finalized last year and took effect on January 1, 2021—beginning with the removal of 298 musculoskeletal procedures from the list. CMS is now proposing to add those procedures back to the IPO beginning on January 1, 2022. CMS is also soliciting feedback on whether the agency should continue to pursue the eventual elimination of the IPO or instead maintain a more refined, shorter list of procedures designated as inpatient only. **The entire list of procedures being added back to the IPO for 2022 can be found in Table 35. Performance of total knee and hip arthroplasty in the outpatient setting will not be impacted, as those procedures were removed prior to 2021.** The request for feedback poses the following questions:

- "Should CMS maintain the longer-term objective of eliminating the IPO list? If so, what is a reasonable timeline for eliminating the list? What method do stakeholders suggest CMS use to approach removing codes from the list?

- Should CMS maintain the IPO list but continue to streamline the list of services included on the list and, if so, suggestions for ways to systematically scale the list back to allow for the removal of codes, or groups of codes, that can safely and effectively be performed on a typical Medicare beneficiary in the hospital outpatient setting so that inpatient only designations are consistent with current standards of practice?

- What effect do commenters believe the elimination or scaling back of the IPO list would have on safety and quality of care for Medicare beneficiaries?

- What effect do commenters believe elimination or the scaling back of the IPO list would have on provider behavior, incentives, or innovation?

- What information or support would be helpful for providers and physicians in their considerations of site-of-service selections?

- Should CMS' clinical evaluation of the safety of a service in the outpatient setting consider the safety and quality of care for the typical Medicare beneficiary or a smaller subset of Medicare beneficiaries for whom the outpatient provision of a service may have fewer risk factors?

- Are there services that were removed from the IPO list in CY 2021 that stakeholders believe meet the longstanding criteria for removal from the IPO list and should continue to be payable in the outpatient setting in CY 2022? If so, what evidence supports the conclusion that the service meets the longstanding criteria for removal from the IPO list and is safe to perform on the Medicare population in the outpatient setting?"

Updates to the 2-Midnight Rule

To align with the removal of the IPO, last year CMS finalized a policy to exempt procedures that had been removed from the IPO from certain medical review activities to determine compliance with the 2-Midnight Rule for a period of two calendar years following the procedure's removal from the IPO.

CMS later updated that policy to allow for indefinite exemption from the site-of-service claim denials, Beneficiary and Family Centered Care-Quality Improvement Organizations (BFCC-QIO) referrals to Recovery Audit Contractors (RACs), and RAC reviews for patient status/site-of-service until there was enough Medicare claims data to show that the procedure was more frequently performed in the outpatient setting than in the inpatient setting.

Given the plan to reverse the elimination of the IPO, **CMS is proposing to eliminate the indefinite exemption and return to the policy of a two-year exemption for procedures removed from the IPO.**

Changes to the Ambulatory Surgical Center Covered Procedures List

In the CY 2021 final rule, CMS determined that the surgical procedures could be added to the Ambulatory Surgical Center Covered Procedures List (ASC-CPL) using a limited set of criteria. This specifically excluded the following criteria which had been used to guide this decision in CY 2020 and years prior:

- Generally result in extensive blood loss;
- Require major or prolonged invasion of body cavities;
- Directly involve major blood vessels;
- Generally emergent or life threatening in nature;
- Commonly require systemic thrombolytic therapy.

As a result of that change, 267 surgical procedures were added to the ASC-CPL for calendar year 2021. Upon further review, however, **CMS has now determined that 258 of these procedures "pose a significant safety risk" to the average Medicare beneficiary and is subsequently proposing to reinstate the above criteria as factors which must be considered prior to the addition of a surgical procedure to the ASC-CPL**. Read the full list of procedures being removed from the ASC-CPL in Table 45.

Moving forward, CMS proposes to implement a stakeholder nomination process to add procedures to the ASC-CPL.

Interoperability and Quality Payment

In alignment with the 2022 Inpatient Prospective Payment System Proposed Rule & 2022 Medicare Physician Fee Schedule Proposed Rule, CMS is issuing an RFI on Advancing to Digital Quality Measurement and the Use of Fast Healthcare Interoperability Resources (FHIR) within the scope of the Outpatient Quality Programs.

CMS is proposing the below additions to the Hospital Outpatient Quality Reporting (OQR) Program measure set:

COVID-19 Vaccination Coverage Among Health Care Personnel (HCP) measure, beginning with the CY 2022 reporting period

- This measure assesses the proportion of a hospital's health care workforce that has been vaccinated against COVID-19. Measure specifications are described on pg. 531.

- Hospitals would be required to report this measure quarterly due to the immediacy of the COVID-19 pandemic.
- Breast Screening Recall Rates measure, beginning with the CY 2022 reporting period
- STEMI eCQM, beginning as a voluntary measure with the CY 2023 reporting period, and then as a mandatory measure beginning with the CY 2024 reporting period.

CMS is renewing its effort to include OP–37a–e: Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey-Based Measures in the Hospital OQR Program.

It is proposing voluntary data collection and reporting beginning with the CY 2023 reporting period, followed by mandatory data collection and reporting beginning with the CY 2024 reporting period/CY 2026 payment determination.

CMS requests comment on "the potential future adoption of measures for our consideration that address care quality in the hospital outpatient setting given the transition of procedures from inpatient settings to outpatient settings of care."

As they did in the FY 2022 Medicare Inpatient Prospective Payment System Proposed Rule, CMS is soliciting comment on including a re-specified version of the Hospital-Level, Risk-Standardized Patient Reported Outcomes Measure Following Elective Primary Total Hip and/or Total Knee Arthroplasty (THA/TKA) measure (NQF #3559) in future years of the Hospital OQR Program. The measure would need to be adapted to the outpatient setting.

As with the Hospital OQR Program, CMS proposes adding the COVID-19 Vaccination Coverage Among Health Care Personnel (HCP) measure to the Ambulatory Surgical Center Quality Reporting (ASCQR) Program beginning with the CY 2022 reporting period.

CMS proposes requiring reporting of the following previously suspended measures beginning with the CY 2023 reporting period.

- ASC-1: Patient Burn
- ASC-2: Patient Fall
- ASC-3: Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant
- ASC-4: All-Cause Hospital Transfer/Admission

Similar to proposals in the Hospital OQR program, CMS wants to resume implementation of ASC–15a–e: Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey-Based Measures. CMS proposes voluntary submission beginning with

the CY 2023 reporting period and transitioning to mandatory reporting beginning with the CY 2024 reporting period.

Table 52 lists the ASCQR Program Measure Set proposed for the CY 2022 reporting period.

CMS makes similar requests for comment on how to address the transition of procedures to the ASC in the ASCQR Program and the future inclusion of an ASC-Level, Risk-Standardized Patient Reported Outcomes Measure Following Elective Primary Total Hip and/or Total Knee Arthroplasty (THA/TKA).

From analysis of CY 2019 and CY 2020 Medicare claims data, CMS sees pain management surgical procedures as a significant portion of procedures performed in the ASC setting. Thus, they seek feedback on the future development and inclusion of a pain management measure in the ASCQR Program measure set.

Safe Use of Opioids - Concurrent Prescribing eCQM (NQF # 3316e) and eCQM Reporting Requirements in the Hospital IQR Program – Request for Information

"The Safe Use of Opioids eCQM is scheduled to be submitted to the National Quality Forum (NQF) in 2022 for reendorsement consideration as part of the measure maintenance process. The purpose of this RFI is to gather public input for potential measure updates as we prepare for NQF re-endorsement of the endorsed Safe Use of Opioids – Concurrent Prescribing eCQM and to potentially inform any future rulemaking regarding this measure."

CMS makes a similar RFI on Safe Use of Opioids - Concurrent Prescribing eCQM (NQF # 3316e) and eCQM reporting requirements as it relates to the Medicare Promoting Interoperability Program.

Price Transparency

In response to noncompliance with the hospital price transparency requirements implemented on January 1, 2021, CMS is proposing to implement a civil monetary penalty using a scaling factor to set the penalty rate for each noncompliant hospital.

CMS proposes the below scaling approach to set the amount of the civil monetary penalty:

● For a noncompliant hospital with a number of beds equal to or less than 30, the maximum daily dollar CMP amount would be $300.

● For a noncompliant hospital with a number of beds between 31 and 550, the maximum daily dollar CMP amount would be the number of beds times $10.

● For a noncompliant hospital with a number of beds greater than 550, the maximum daily dollar CMP amount would be $5,500.

Health Equity

To expand efforts to promote health equity, CMS seeks comment on the idea of stratifying performance results of six priority measures by dual eligibility:

- MRI Lumbar Spine for Low Back Pain (OP-8)
- Abdomen CT – Use of Contract Material (OP-10)
- Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low Risk Surgery (OP-13)
- Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy (OP-32)
- Admissions and ED Visits for Patients Receiving Outpatient Chemotherapy (OP-35)
- Hospital Visits after Hospital Outpatient Surgery (OP-36)

CMS is seeking public comment on potential future confidential reporting of these six measures stratified by dual eligibility status.

CMS is exploring the idea of using dual eligibility as a proxy for social risk in Facility-Specific Reports and on the Care Compare website.

To learn more, read AAOS' long-form summary of the proposed rule.

All of the tables referenced can be found here.

The complete rule text can be read here.