

AAOS CY 2023 Medicare Hospital Outpatient Prospective Payment/Ambulatory Surgical Center Proposed Rule Summary

On July 15, 2022, the Centers for Medicare & Medicaid Services (CMS) released the Calendar Year (CY) 2023 Medicare Hospital Outpatient Prospective Payment System/Ambulatory Surgical Center (OPPS/ASC) proposed rule. 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 be submitting comments by September 13, 2022. Below is a description of relevant proposals:

Updates to OPPS and ASC Payment Rates

CMS is proposing to update OPPS payment rates for hospitals that meet applicable quality reporting requirements by 2.7%. This update is based on the projected hospital market basket percentage increase of 3.1%, reduced by 0.4 percentage point for the productivity adjustment.

In the CY 2019 OPPS/ASC final rule with comment period, CMS finalized the proposal to apply the productivity-adjusted hospital market basket update to ASC payment system rates for an interim period of 5 years (CY 2019 through CY 2023). Using the proposed hospital market basket update, CMS is proposing to update the ASC rates for CY 2023 by 2.7%. The proposed update applies to ASCs meeting relevant quality reporting requirements.

Rural Emergency Hospitals Physician Self- Referral Law Update

- In the CY 2023 OPPS/ASC proposed rule, CMS is proposing updates to the physician self-referral law for the new REH provider type. Specifically, CMS is proposing (1) a new exception for ownership or investment interests in an REH; and (2) revisions to certain existing exceptions to make them applicable to compensation arrangements to which an REH is a party.

Proposed Use of June 2020 Cost Report and CY 2021 Claims Data for CY 2023 OPPS and ASC Payment System Rate Setting Due to the PHE

- Consistent with CMS' typical practice, for CY 2023 they propose to use claims data from CY 2021. CMS considers the claims data from the two years prior the best available data to accurately reflect estimates of the costs associated with furnishing outpatient services.
- However, the most recent available cost report data include periods that overlap with CY 2020. CMS believes that the CY 2020 cost report data are not the best overall approximation of expected outpatient hospital services, because that would include data from the start of the PHE. In order to mitigate the impact of some of the temporary changes in hospitals' cost report data from CY2020,

CMS is proposing to use cost report data from the June 2020 Healthcare Cost Report Information System (HCRIS), which only includes cost report data through CY 2019, predating the PHE. This is the same cost report extract used to set OPPS rates for CY 2022. CMS believes using the CY 2021 claims data, with cost reports data through CY 2019 for CY 2023 OPPS rate setting, is the best approximation of expected costs for CY 2023 hospital outpatient services for rate setting purposes. As a result, CMS is proposing to use CY 2021 claims data with cost report data through CY 2019 (prior to the PHE) to set CY 2023 OPPS and ASC payment system rates.

Changes to the Inpatient Only List

- The inpatient only (IPO) list identifies services for which Medicare will only make payment when the services are provided in the inpatient hospital setting due to the invasive nature of the procedure, underlying physical condition of the patient, or the need for at least 24 hours of postoperative care/monitoring. CMS works along with other healthcare entities to annually evaluate the current IPO list to determine whether services should be added or removed and utilizes five different criteria to make a determination, including procedures currently performed safely in approved Ambulatory Surgery Centers (ASCs).
- CMS has at times had to reclassify codes as inpatient only services with the emergence of new information. In the CY 2021 OPPS/ASC final rule with comment period, CMS finalized a policy to eliminate the IPO list over the course of 3 years, using the above-mentioned criteria list. The first phase of this elimination removed 298 codes, including 266 musculoskeletal-related services, from the list beginning in CY 2021. However, after clinical review of the services removed from the IPO list, CMS halted the elimination of the IPO list and in the CY 2022 OPPS/ASC final rule with comment period returned most services back to the IPO list beginning in CY 2022.
 - For CY 2023, CMS identified and proposed to remove CPT code 22632, *Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (list separately in addition to code for primary procedure)*.
 - For CY 2023, CMS is proposing to add 228XX, Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); second interspace, lumbar (List separately in addition to code for primary procedure)
- CMS proposes to remove code 22632 from the IPO list for CY 2023. CPT code 22632 is an add-on code that is typically billed with the primary procedure described by CPT code 22630, *Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar*, which was removed from the IPO list in CY 2021. CPT code 22632 was previously removed from the IPO list in CY 2021 but was then returned to the IPO list for CY 2022 when the elimination of the IPO list was halted. After clinical review, CMS believes code 22632 meets two of the criteria listed in the regulation text because the simplest procedure described by the code may be performed in most outpatient departments and it is related to CPT code 22630, which CMS has already removed from the IPO list. For CY 2023, CMS further proposes to assign CPT code 22632 to status indicator

“N” (meaning there is no separate payment because reimbursement is packaged into the payment for other services) and is seeking public comment on the decision that the service described by CPT code 22632 meets said criteria as well as the proposed assignment to status indicator “N” for CY 2023.

Changes to the ASC Covered Procedures List

- The ASC Covered Procedures List (CPL) specifies the list of procedures that can be safely performed in an ASC. CMS evaluates the ASC CPL each year to determine whether the procedures should be added to or removed from the list. There are several new Level II HCPCS codes to the list of covered ancillary services that were implemented April 1, 2022. These new codes were effective April 1, 2022, are assigned to comment indicator "NP" meaning the "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, proposed ASC payment indicator; comments will be accepted on the proposed ASC payment indicator for the new code." CMS is proposing to finalize the payment indicators in CY 2023 OPPS/ASC final rule with comment period.) New level II codes for Ancillary Services Effective April 1, 2022, of interest include:
- C9781, Arthroscopy, shoulder, surgical; with implantation of subacromial spacer (eg, balloon), includes debridement (e.g., limited, or extensive), subacromial decompression, acromioplasty, and biceps tenodesis when performed
 - This code is also subject to multiple procedure discounting and has a payment indicator of “J8” (Device-intensive procedure; paid at adjusting rate).

OPPS Payment for Drugs Acquired Through 340B Program

- The OPSS 340B policy has been the subject of litigation. CMS cites the recent Supreme Court decision in *American Hospital Association v. Becerra* (No. 20-1114, 2022 WL 2135490) in which SCOTUS held that HHS may not vary payment rates for drugs and biologicals among groups of hospitals in the absence of having conducted a survey of hospitals’ acquisition costs. The Supreme Court’s decision concerned payment rates for CYs 2018 and 2019, but it has implications for CY 2023 payment rates. Due to the timing of this decision, CMS was unable to adjust the proposed payments rates and budget neutrality calculations to account for that decision before issuing this proposed rule. For CY 2023, CMS is formally proposing a payment rate of ASP minus 22.5% for drugs and biologicals acquired through the 340B Program, consistent with prior policy. CMS fully anticipates applying a rate of ASP plus 6% to such drugs and biologicals in the final rule for CY 2023, considering the Supreme Court’s recent decision. CMS continues to evaluate how to apply the Supreme Court’s recent decision to prior calendar years. Impacts for both policy options are included in the addenda to the proposed rule.

Payment for Non-Opioid Products Under Section 6082 of the Support Act

- By law, the Secretary must review payments under the OPSS and ASC for opioids and non-opioid alternatives

for pain management. The purpose of this is to ensure that there are no financial incentives in using opioids rather than non-opioids alternatives. For CY 2023, CMS is proposing to maintain its current policy to provide separate payment for non-opioid pain management drugs and biologicals that are FDA-approved for pain management and function as supplies in the ASC setting, with a daily cost over the OPPS drug packaging limit.

- For CY 2023, CMS is proposing separate payment in the ASC setting for four non-opioid pain management drugs that function as surgical supplies, including certain local anesthetics and ocular drugs, that meet the criteria in 42 CFR 416.174.

Proposed IPPS and OPPS Payment Adjustments for Additional Costs of Domestic NIOSH-Approved Surgical N95 Respirators

- The National Institute for Occupational Safety and Health (NIOSH) approved surgical N95 respirators are crucial for the protection of patients as well as hospital personnel. However, due to the severe shortage of surgical N95 respirators at the onset of the pandemic, a level of domestic production of NIOSH-approved surgical N95 respirators from domestic manufacturers must be maintained to help with the availability in a timely basis. CMS recognizes the additional costs to hospitals for the domestic manufactured surgical N95 respirators, and therefore CMS is proposing to make a payment adjustment under the OPPS and IPPS beginning on or after January 1, 2023. Specifically for OPPS, CMS is proposing to make this payment adjustment ensure payments are made to maintain budget neutrality. (460)

Promoting Competition and Transparency Regarding the Effects of Provider Mergers, acquisitions, Consolidations, and Changes in Ownership

- President Biden's Executive Order, "Promoting Competition in the American Economy" released on July 9, 2021, was created in an effort to promote competition and specified how hospital consolidations have left many rural communities without adequate, affordable health care options as hospitals in consolidated markets charge higher fees. For the sake of transparency, CMS released data dating back from 2016 showing the effects of mergers, acquisitions, consolidations, and changes in ownership. CMS will continue to update this data quarterly.
- To address abuses of market power, unfair competition, and the effects of monopoly, CMS is seeking information from the public on how the collected data could be used to promote competition and/or safeguard the public from the effects of healthcare consolidation.

Rural Sole Community Hospital Exemption to the Clinic Visit Payment Policy

- CMS currently pays the Physician Fee Schedule (PFS)-equivalent payment rate for the clinic visit service when provided at an excepted off-campus provider-based department (PBD) paid under the OPPS, as a method to

control the unnecessary increases in volume CMS had observed for that covered outpatient department service. The PFS-equivalent payment rate is approximately 40% of the OPSS payment rate, and the clinic visit is the most frequently billed service under the OPSS. In order to maintain access to care in rural areas, CMS is proposing to exempt Rural Sole Community Hospitals (SCHs) from this policy and pay for clinic visits furnished in excepted off-campus PBDs of these hospitals at the full OPSS rate. CMS believes that implementing this exemption would help to maintain access to care in rural areas by ensuring rural providers are paid for clinic visit services provided at off-campus PBDs at rates comparable to those paid by on-campus departments. This proposed exemption for rural SCHs is in keeping with prior CMS policies to provide rural SCHs a 7.1% add-on payment for OPSS services, to account for their higher costs compared to other hospitals, and to exempt rural SCHs from the 340B payment adjustment policy.

OPSS Transitional Pass-through Payment for Drugs, Biologicals, and Devices

- CMS is proposing to publicly post the completed OPSS device pass-through application forms and related materials that they receive from applicants online. This would not pertain to certain copyright or other materials that can't be released to the public. This would begin with applications received on or after January 1, 2023. However, CMS is not proposing a one-year extension for technologies whose transitional pass-through period is set to expire on December 31, 2022.

OPSS Payment for Software as a Service

- New clinical software, which includes clinical decision support software, clinical risk modeling, and computer aided detection (CAD), are becoming increasingly available to providers. CMS refers to these algorithm-driven devices as Software as a Service (SaaS) and is asking for feedback on payment for utilization of these SaaS services.

Hospital Outpatient/ASC/REH Quality Reporting Programs

- CMS is "proposing changes, as well as requesting comments, for the Hospital Outpatient Quality Reporting (OQR), Ambulatory Surgical Center Quality Reporting (ASCQR), and Rural Emergency Hospital Quality Reporting (REHQR) Programs to further meaningful measurement and reporting for quality of care in the outpatient setting."

Hospital Outpatient Quality Reporting (OQR) Program

- Because the shift from the inpatient to outpatient setting has placed greater importance on tracking the volume of outpatient procedures, CMS is seeking comments from the public on future reimplementation of the Hospital Outpatient Volume on Selected Outpatient Surgical Procedures (OP-26) measure or the future

adoption of another volume indicator as a quality measure.

- In the FY 2023 IPPS/LTCH PPS proposed rule, there is a Request for Information (RFI) titled “Overarching Principles for Measuring Healthcare Quality Disparities Across CMS Quality Programs,” which describes key considerations that CMS is considering across all CMS programs. CMS is requesting that readers review the full RFI in the proposed rule and respond.

Protecting Program Sustainability

- CMS continues to prioritize reducing unnecessary increases in the volume of certain covered outpatient department (OPD) services through the use of a prior authorization process. In the CY 2023 OPPI/ASC proposed rule, CMS is proposing to require prior authorization for an additional service category: Facet Joint Injections and Nerve Destruction. This proposal would ensure Medicare beneficiaries receive medically necessary care while protecting the Medicare Trust Funds from unnecessary increases in volume by virtue of improper payments without adding new documentation requirements for providers.

Sources:

[CY 2023 OPPI Fact Sheet](#)

[CY 2023 OPPI Proposed Rule](#)