

## 2020 Outpatient Prospective Payment System Proposed Rule Executive Summary

### *Expansion of Settings of Care*

One procedure is being proposed for removal from the inpatient only (IPO) list: Current Procedural Terminology (CPT) code 27130 (Arthroplasty, acetabular and proximal femoral prosthetic replacement [total hip arthroplasty] with or without autograft or allograft).

The Centers for Medicare & Medicaid Services (CMS) is proposing to remove total hip arthroplasty (THA) from the IPO and assign it to Comprehensive Ambulatory Payment Classification (C-APC) 5115 with status indicator J1. To ameliorate confusion surrounding the initial removal of THA from the IPO list, CMS is proposing to establish a one-year exemption from Recovery Audit Contractor (RAC) referrals for noncompliance with the two-midnight rule. Additionally, THA would not be considered for persistent provider noncompliance with the two-midnight rule by Beneficiary and Family Centered Care-Quality Improvement Organizations (BFCC-QIOs) during this one-year period.

### *List of Ambulatory Surgical Center Covered Surgical Procedures, Ancillary Services*

CMS is proposing to add total knee arthroplasty (TKA) (CPT codes 27447, 29867) to the ambulatory surgical center (ASC) covered procedures list (CPL) for CY 2020. It is seeking public comment on the best approach to provide safeguards for Medicare beneficiaries who should not be eligible to receive TKA procedures in the ASC setting. CMS is also seeking comments on how these proposed additions of ASC covered surgical procedures will impact rural hospitals.

### *Payment for Devices*

Seven applications were received, none of which received approval during the quarterly review process. Of the seven, two devices are indicated for orthopaedic use. CMS is accepting comments on these submissions, as well as feedback to provide greater understanding of CMS' approach to evaluating substantial clinical improvement. The rule proposes language changes such that outpatient prospective payment system (OPPS) device pass-through payment applicants approved under the Food and Drug Administration's (FDA) Breakthrough Devices Program **would not be evaluated** in terms of the current substantial clinical improvement criterion for the purposes of determining device pass-through payment status. They would need, however, to continue to meet the other requirements for pass-through payment status in the regulation.

### *Drugs, Biologicals, and Radiopharmaceuticals*

CMS defines "biological product" or "biologic" as outlined under section 351 of the Public Health Service Act but does not limit the term to only those products.

### ***Nonrecurring Policy Changes***

CMS is proposing to change the generally applicable minimum required level of supervision for hospital outpatient therapeutic services from direct supervision to general supervision for services furnished by all hospitals and critical access hospitals (CAH). General supervision is defined by 42 CFR 410.32(b)(3)(i) as a procedure furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure.

### ***Ambulatory Surgical Center Conversion Factor Update***

CMS is proposing to apply a 2.7 percent Multifactor Productivity-adjusted hospital market basket update factor to the CY 2019 ASC conversion factor.

### ***Treatment of New and Revised Codes***

Comments will be sought on the April and July 2019 HCPCS ASC quarterly update in the CY 2020 proposed rule and finalized in the CY 2020 final rule with comment period. For HCPCS updates published in October 2019, comments will be sought for the CY 2020 final rule with comment period and finalized in the CY 2021 OP/ASC final rule with comment period.

### ***Quality Reporting Program Quality Measures***

CMS is proposing the addition of one new quality measure for the CY 2024 payment determination and subsequent years. ASC-19: Facility-Level Seven-Day Hospital Visits after General Surgery Procedures Performed at ASCs (NQF #3357).

### ***Public List of Hospital Standard Charges***

Per the President's executive order on price transparency, CMS is proposing an expansion of hospital charge display requirements to include charges and information based on negotiated rates for common shoppable services and items in a consumer-friendly format. CMS is proposing to deem federally-owned or operated hospitals that only treat the general public for emergent situations and whose rates are not subject to negotiation as exempt from the new requirements, as long as their hospital charges are posted to patients in advance on the Federal Register or elsewhere.

### ***Definition of "Items and Services" Provided by Hospitals***

"All items and services, including individual items and services and service packages that could be provided by a hospital to a patient in connection with an inpatient admission or an outpatient department visit for which the hospital has established a standard charge." CMS is proposing to include in this definition "the services furnished by physicians and non-physician practitioners who are employed by the hospital."

### ***Surprise Billing***

Direct quote from the proposed rule: "We also considered including in our proposed definition of items and services the services provided by physicians and non-physician practitioners who are not employed by the hospitals, but who provide services at a hospital location. For example, a procedure performed in a hospital setting may involve anesthesiology services provided by a non-employed physician who has established his or her own charge for the service he or she is providing at a hospital location."

### ***Definitions for Types of “Standard Charges”***

CMS believes that standard charges can be further defined as either “gross” or “payer-specific.” A gross charge would be the charge for an individual item or service that is reflected on a hospital’s chargemaster, absent any discounts. The payer-specific definition would be the charge that the hospital has negotiated with a third-party payer for an item or service. CMS is seeking comments on the unintended consequences of releasing specific charge information and alternative methods for increasing out-of-pocket cost transparency.

### ***Public Disclosure of All Hospital Standard Charges for All Items, Services***

CMS is proposing that hospitals will display their payer-specific negotiated charges for the primary shoppable service side-by-side with payer-specific negotiated charges for all ancillary items and services the hospital customarily provides as part of, or in conjunction with, the primary service.

### ***Consumer-Friendly Display of the Payer-Specific Negotiated Charges for Selected Shoppable Services***

CMS is proposing to define “shoppable services” as a service package that can be scheduled in advance and is typically provided in non-urgent situations that do not require immediate action or attention. CMS is proposing that at least 300 shoppable services be displayed in a consumer-friendly format, including at least 70 CMS-selected shoppable services. If a hospital does not provide all 70 of those, then the hospital may choose additional services until it reaches 300. These CMS-selected procedures include major joint replacement, spinal fusion, and removal of one knee cartilage using an endoscope.

### ***Prior Authorization Process for Certain Outpatient Department Services***

CMS is proposing that it may elect to exempt a provider from the prior-authorization process upon a provider’s demonstration of compliance with Medicare coverage, coding and payment rules, and that this exemption would remain in effect until CMS elects to withdraw the exemption. CMS proposes to exempt providers that achieve a prior-authorization provisional affirmation threshold of at least 90 percent during a semiannual assessment. The exemption may take 90 days to go into effect. If the rate of non-payable claims submitted increases above 10 percent during a biannual assessment, CMS may consider withdrawing the exemption.