**CY 2015 Outpatient Prospective Payment System (OPPS) Proposed Rule**

***Member Finance/Reimbursement Outreach***

The Centers for Medicare & Medicaid Services (CMS) recently released the calendar year (CY) 2015 Outpatient Prospective Payment System (OPPS) proposed rule. This rule includes proposed changes to the following policies and programs:

* Payment for device-dependent services under new comprehensive ambulatory payment classifications (C-APCs)
* Claims modifier for data collection in off-campus provider-based departments
* Payment for hospital emergency department (ED) visits

As America’s Essential Hospitals works on its comments, we want to hear from our members so that our comments reflect your concerns. Specifically, we are seeking input on the questions below.

We thank you in advance for your time.

**Comprehensive Ambulatory Payment Classifications (C-APCs)**

1. *C-APCs.* CMS proposes to implement its CY 2014 proposal to pay for device-dependent services using C-APCs. The C-APCs would package all services related to the primary device-dependent service into one prospective payment amount. The C-APC payment amount is based on the cost of the primary service and all of the adjunctive services provided in support of the primary service. Adjunctive services are those services that are provided during the delivery of the comprehensive services, such as lab tests or supplies. CMS will assign a new status indicator, “J1,” that would be assigned to the healthcare common procedure coding system (HCPCS) codes for a comprehensive service. Any time a J1 procedure is on a claim for Medicare outpatient payment, CMS would pay the hospital a single C-APC payment for the primary service and all adjunctive services. In this rule, CMS is proposing to reconfigure and restructure the C-APCs that were finalized last year, as well as add other device-dependent services to the list of C-APCs, resulting in a total of [28 C-APCs for CY 2015](http://essentialhospitals.org/wp-content/uploads/2014/07/CY-2015-OPPS-Table-7-Comprehensive-APCs.pdf).

Most types of adjunctive services payable under the OPPS would be packaged into a C-APC when provided in conjunction with the device-dependent primary services. These adjunctive services that would be packaged into the C-APC include diagnostic procedures, lab tests and diagnostic tests that assist in the delivery of the primary procedure, visits and evaluations associated with the primary procedure, durable medical equipment provided as part of the outpatient service, and HOPD services similar to therapy that are delivered as part of the comprehensive service by therapists or non-therapists. Payment for drugs, biologicals, and radiopharmaceuticals, would also be packaged, except for drugs with pass-through status and self-administered drugs (SADs). In addition to SADs, recurring therapy services, ambulance services, diagnostic and screening mammography, annual wellness visits, pass-through devices, and preventive services will continue to be paid separately from the C-APC payment.

Questions regarding CMS’ proposal to create C-APCs:

1. What kind of administrative burden would be involved in bringing your hospital’s billing and financial systems up to date with CMS’ new C-APCs proposal? How many financial resources and man-hours do you estimate would be required to implement these changes?
2. Is there enough time for your hospital to adjust its budget to account for any losses in reimbursement projected under the new methodology?
3. For billing purposes, is it difficult to tell if an adjunctive service is related to the primary procedure? How do you separate out the adjunctive services from the primary procedure on your claims?
4. How does the shift from separate payment for device-dependent APCs and adjunctive services to packaged payment for C-APCs affect your hospital’s reimbursements?
5. In the attached spreadsheet are four examples of C-APCs, the primary services assigned to these C-APCs, and CMS’ calculated payment rate for these C-APCs. How would payment for these procedures under the C-APC proposal compare to payment under the existing methodology at your hospital?
   * + Level II Pacemaker and Similar Procedures (APC 0090)
     + Level IV Pacemaker and Similar Procedures (APC 0655)
     + Level I Electrophysiologic Procedures (APC 0084)
     + Level III Electrophysiologic Procedures (APC 0086)
6. CMS proposes to package payments for blood and blood products in the C-APC when the blood and blood products are administered as part of a comprehensive service—what would be the impact of doing so for your hospital?
7. *C-APC complexity adjustment*: To account for complex cases where the primary JI procedure appears on a claim with certain other procedures, CMS will apply a complexity adjustment. When certain combinations of two JI procedures are on a claim, or combinations of J1 procedures and certain add-on codes are on a claim, CMS will pay the hospital the next-highest C-APC amount in the clinical family. CMS has identified the [52 different higher-cost procedure combinations](http://essentialhospitals.org/wp-content/uploads/2014/07/2015-OPPS-C-APC-complexity-adjustments.xls) to which it will apply a complexity adjustment.

Questions regarding CMS’ C-APC complexity adjustment proposal:

* + - 1. Are the proposed complexity adjustments the types of procedure combinations that are more complex and require more resources in your hospital?
      2. What other outpatient device-dependent procedures or combinations of procedures require more resources at your hospital?

**Claims Modifier for Data Collection in Off-Campus Provider-Based Departments**

1. Beginning with CY 2015, CMS proposes to require hospitals to report a HCPCS modifier with every code for outpatient hospital services provided in off-campus provider-based departments on their UB-04 form (CMS Form 1450) and physicians to report the modifier with every code for physicians’ services on the CMS-1500 claim form. CMS intends to use this modifier to collect data on the frequency, type, and payment for services furnished in off-campus provider-based departments. CMS would use this data to understand hospitals’ practice of acquiring off-campus physician offices and treating them as outpatient departments.

Questions regarding CMS’ proposal to use a claims modifier to collect data:

1. Is reporting a modifier on hospital claims beginning with CY 2015 going to be feasible for your hospital to implement?
2. What would it entail from an operational perspective?
3. How much more burden is it to include this modifier?
4. Is there a better way that CMS can gather this information?

**Payment for Hospital Emergency Department (ED) visits**

1. CMS will not proceed with any changes in coding for Type A and Type B ED visits until it has conducted thorough evaluation to determine the most appropriate payment structure for ED visits. Last year, CMS collapsed the ten levels of clinic visit to one new HCPCS code and had proposed to (but did not finalize) collapse Type A and Type B visits codes into one code each.

Questions regarding payment for hospital ED visits:

1. What is the current breakdown of the five Level 1 through Level 5 Type A (HCPCS codes 99281; 99282; 99283; 99284; and 99285) and Type B ED visits (HCPCS codes G0380; G0381; G0382; G0383; and G0384) by level at your hospital?
2. Are ED visits at your hospital more skewed towards certain level codes?
3. Have you experienced any changes in reimbursement from the collapsing of the ten clinic visit codes? If so, what have been the resulting changes?