Outpatient Facility Coding Alert

OPPS 2014: Get Ready for These OPPS Changes From CMS That Will Affect You in 2014

A single outpatient clinic code will change your reporting strategy.

Packaged service categories, outpatient visit coding, and more will change for outpatient facilities in 2014. Read on for details you need to know, straight from CMS's final Calendar Year (CY) 2014 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System Policy Changes and Payment Rates final rule with comment period [CMS-1601-FC] that was released on December 10, 2013.

Pay Attention to Updated Packaged Service Categories

When the OPPS began in 2000, the payment system provided for the packaging of a limited number of items and services, such as anesthesia and surgical supplies. CMS later expanded the categories of packaged items and services by adding a number of additional categories, including image processing services and implantable biologicals. CMS had proposed to package an additional seven categories of services for 2014. However, based on public comments, CMS decided to only package five of the seven proposed categories.

The newly packaged categories will be:

- Drugs, biologicals, and radiopharmaceuticals used in a diagnostic test or procedure;
- Drugs and biologicals when used as supplies in a surgical procedure;
- Certain clinical diagnostic laboratory tests;
- Procedures described by add-on codes; and
- Device removal procedures.

Rationale: CMS believes that packaging services gives hospitals the incentive to negotiate more effectively with suppliers to lower costs and to provide care in the most efficient manner. Packaging payments into larger payment bundles can also give more accurate projections of payment for services over time.

"CMS has stepped up packaging since 2008 to the point where we going back to APGs (Ambulatory Patient Groups), the precursor to APCs," according to Duane Abbey, president of Abbey & Abbey, Consultants, Inc., in Ames, Ia.

How it works: Hospitals include HCPCS codes and charges for packaged services on their claims. The estimated costs associated with those packaged services are then added to the costs of separately payable procedures on the same claims. Even when services might be packaged, CMS directs hospitals to still report all HCPCS codes for provided services unless the CPT® Editorial Panel or CMS provides other specific guidance.

Narrow One Outpatient Clinic Visit Options to One

The Final Rule condenses the current five levels of outpatient clinic visit codes into a single HCPCS code describing all clinic visits. This includes both new patient visits and established patient visits.

HCPCS G0463 (Hospital outpatient clinic visit for assessment and management of a patient) is the new, single code that replaces the ten code sequence 99201-99215. G0463 maps into APC 0634 with a national payment of $92.53.

"Note that the new code has Status Indicator Q3," says Abbey. "Thus, G0463 may be bundled under certain circumstances.

"It is amazing that CMS would make this change," Abbey adds. "Just last year, because of significant cost variations, CMS refused to combine the new patient and established patient visits into a single sequence of five codes."

Rationale: The current five levels of outpatient visit codes are designed to distinguish differences in physician work. CMS states that the new single code will be easier from a reporting and reimbursement standpoint and will better reflect the hospital resources involved in supporting an outpatient visit.

ED note: The final rule with comment period does not finalize the proposal to replace the current five levels of codes for each type of emergency department visits. CMS intends to consider options to improve the codes for these services in future rulemaking.

Watch for Bottom-Line Changes

The Medicare statute requires a productivity adjustment reduction of 0.5 percentage points and a 0.3 percentage point reduction to the CY 2014 OPPS market basket. This leads to the following updates for 2014:

- The Final Rule updates the OPPS market basket by 1.7 percent for CY 2014.
- The final hospital market basket increase published in the Fiscal Year (FY) 2014 Inpatient Prospective Payment System (IPPS)/Long-Term Care Hospital Prospective Payment System (LTCH PPS) final rule is 2.5 percent.

The final rule with comment period and final rules appeared in the December 10, 2013, Federal Register and can be downloaded from the Federal Register at: https://www.federalregister.gov/articles/2013/12/10/2013-28737/medicare-and-medicaid-programs-hospital-outpatient-prospective-payment-and-ambulatory-surgical. There are just a few issues to which comments can be made. The due date for any comments is January 27, 2014. Most of the directives are final with implementation on January 1, 2014.