CMS Proposes Changes to Hospital Outpatient Prospective Payment System

On August 4th, 2020 the Centers Medicare and Medicaid Services (CMS) released the calendar year (CY) 2021 Hospital Outpatient Prospective Payment System (HOPPS) proposed rule. This rule provides for a 60-day comment period ending on October 5, 2020. The finalized changes will appear in the final rule and are effective January 1, 2020.

CMS proposes to increase the conversion factor by 2.6 percent, therefore increasing it to $80.793 for CY 2021. The reduced conversion factor for hospitals failing to meet the Hospital Outpatient Quality Reporting (OQR) Program requirements is proposed to be $82.065.

For CY 2021 and subsequent years, CMS proposes to change the minimum default level of supervision for non-surgical extended duration therapeutic services (NSEDTS) to general supervision for the entire service, including the initiation portion of the service, for which previously required direct supervision. Additionally, CMS proposes that beginning in CY 2021 and subsequent years, direct supervision for pulmonary rehabilitation, cardiac rehabilitation, and intensive cardiac rehabilitation services would include virtual presence of the physician through audio/video real-time communications technology subject to the clinical judgment of the supervising physician.

CMS proposes the addition of the following two categories of services to the prior authorization process beginning for dates of service on or after July 1, 2021: (1) cervical fusion with disc removal and (2) implanted spinal neurostimulators.

Beginning in CY 2021, CMS proposes to fully implement the CT and MR cost data regardless of the cost allocation method. The ACR has raised concerns repeatedly in the past regarding the use of claims from hospitals that continue to report under the "square foot" cost allocation method noting that it would under-estimate the true costs of CT and MR studies. CMS has given hospitals six years to adjust their cost allocation methods from "square foot" to either "direct" or the "dollar" method. These changes are the result of a study that was done by the Research Triangle Institute (RTI) back in 2007[1]. Although ACR has argued that the RTI study, and data which back it up are outdated, CMS is adamant to continue with fully implementing its recommendations on how to better represent cost center data in the hospital setting. CMS states they continue to monitor OPPS imaging payments in the future and consider the potential impacts of payment changes on the PFS and the ASC payment system.

In the CY 2021 HOPPS Proposed Rule, CMS proposes to place 712X0 (Low Dose CT for Lung Cancer Screening) in the lowest Imaging without Contrast APC (5521), with payment rate of $82.15. In addition, CMS has proposed to place G0296 (visit to determine lung LDCT eligibility) in APC 5822, with a payment

[1] Cromwell, J., & Dalton, K. (2007, January). *A Study of Charge Compression in Calculating DRG Relative Weights* (Rep.). Retrieved July 1, 2019, from Centers for Medicare and Medicaid Services website: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads/Dalton.pdf

rate of $75.26. The ACR has raised concerns about the inadequate payments for CT lung screening based on flawed hospital data in the past rules.

For CY 2021, CMS proposes to create two new comprehensive APCs (C-APCs). These proposed new C-APCs include the following: C-APC 5378 (Level 8 Urology and Related Services) and C–APC 5465 (Level 5 Neurostimulator and Related Procedures). Adding these C-APCs would increase the total number of C-APCs to 69.

A detailed analysis of the proposed changes will be released in the coming days.