ALLIANCE OF
WOUND CARE
STAKEHOLDERS
POWER THROUGH COLLECTIVE ADVOCACY

Summary of the Final Outpatient Prospective Payment System (OPPS) Rule issued on November 1, 2019
Issues of Interest to Alliance Members

CMS received over 3400 comments on the proposed rule. The Alliance commented on several provisions within the OPPS proposed rule which CMS took under advisement, but ultimately moved forward and finalized the rule without implementing any of our recommendations.

1. Supervision Requirements

CMS will be moving forward with general supervision for all outpatient services beginning January 1, 2020. In their response, CMS did acknowledge the concerns that we raised but ultimately stated the following:

We agree with the commenters about the importance of ensuring the quality of outpatient therapeutic services and the health and safety of the beneficiaries who receive those services. We also appreciate the concerns several commenters raised about how this proposal will affect the quality and safety of outpatient therapeutic services including radiation therapy, hyperbaric oxygen treatments, and wound care services. We believe our supervision requirements continue to provide the safeguards Medicare beneficiaries need to ensure they receive quality care when they receive outpatient hospital therapeutic services and that health and safety of beneficiaries is protected.

Providers have the flexibility to establish what they believe is the appropriate level of physician supervision for these procedures, which may well be higher than the requirements for general supervision.

We were not the only ones concerned about this change. Even MEDPAC submitted comments and were concerned about the quality of care that beneficiaries would receive. MEDPAC stated:

MedPAC strongly encourages CMS to diligently monitor the impacts of the CMS proposal on the quality and safety of outpatient therapeutic services that Medicare beneficiaries receive to ensure their quality of care is not compromised and that beneficiaries do not experience higher rates of medical errors.

CMS has stated that to ease the concerns of commenters, providers will have the flexibility to establish what they believe is the appropriate level of physician supervision for these procedures, which may well be higher than the requirements for general supervision

2. Time for HOPPS Panel Meeting

The Alliance further recommended that the Hospital Advisory Panel meetings should be held 21 days after the proposed rule is issued in order to give stakeholders time to review the proposals and provide meaningful testimony to the Panel. CMS stated that this comment was outside the scope of the proposed rule and they

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would continue to hold the Advisory meetings on the scheduled dates regardless of when the proposed rule is issued.

3. CTP Payment Methodology

CMS also evaluated all the comments received on the CTP payment methodology. For the time being everything is status quo. Specifically, CMS will continue to assign CTPs with pass-through payment status to the high cost category, assign CTPs with pricing information but without claims data to calculate a geometric MUC or PDC to either the high cost or low cost category based on the product's ASP+6 percent payment rate as compared to the MUC threshold. If ASP is not available, CMS will use WAC+3 percent to assign a product to either the high cost or low cost category. Finally, if neither ASP nor WAC is available, CMS will use 95 percent of AWP to assign a CTP to either the high cost or low cost category. CMS will continue to use WAC+3 percent instead of WAC+6 percent. New CTPs without pricing information would be assigned to the low cost category until pricing information is available to compare to the CY 2020 MUC threshold. CTPs that were assigned to the high cost bucket will remain there for 2020.

CMS did have a significant discussion in the response to comments re: the payment methodologies proposed – including lump-sum "episode-based" payment for a wound care episode, elimination of the high cost and low cost categories for skin substitutes and have only one payment category and set of procedure codes for the application of all graft skin substitute products and single APC but did not indicate which direction the Agency is going to take.

4. Interim APC assignments and/or status indicators of new or replacement Level II HCPCS

Finally, if there is interest in submitting comments on the payment classifications assigned to the interim APC assignments and/or status indicators of new or replacement Level II HCPCS codes in this final rule with comment period, comments must be received n no later than 5 p.m. EST on December 2, 2019.