Issue Brief

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Proposed Update to the CY 2023 Hospital Outpatient and ASC Prospective Payment Systems Released

The Centers for Medicare and Medicaid Services (CMS) have issued a proposed rule with comment period that updates policies and payment rates for services furnished to Medicare beneficiaries in hospital outpatient departments (HOPDs) and in ambulatory surgical centers (ASCs) beginning January 1, 2023 (CY 2023).

The rule would update and refine the requirements for the Hospital Outpatient Quality Reporting (OQR) Program and the ASC Quality Reporting (ASCQR) Program. CMS is also proposing updates to the requirements for Organ Acquisition, Prior Authorization, and Overall Hospital Quality Star Rating. CMS is establishing a new provider type for rural emergency hospitals (REHs), and have proposals regarding payment policy, quality measures, and enrollment policy for REHs.

The document is scheduled to be published in the ***Federal Register*** on July 26. A comment period ending September 13 is provided. A copy of the 886-page document is currently available at: https://public-inspection.federalregister.gov/2022-15372.pdf.

The Addenda relating to the OPPS are available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices.

The Addenda relating to the ASC payment system are available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASCRegulations-and-Notices.

COMMENT

CMS estimates "that the total increase in Federal Government expenditures under the OPPS for CY 2023, compared to CY 2022, due only to the changes to the OPPS would be approximately $1.79 billion. Taking into account estimated changes in enrollment, utilization, and case-mix for CY 2023, CMS estimates that the OPPS expenditures, including beneficiary cost-sharing, would be approximately $86.2 billion, which is approximately $6.2 billion higher than estimated OPPS expenditures in CY 2022."

While this rulemaking has a table of contents identifying major headings, it is only identifying major categories.

Again, this is another rule that has much unneeded and redundant history that is no longer relevant nor helpful. In fact, such material becomes confusing and distracting in helping the reader find the relevant changes being made for CY 2022.

continued

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I. SUMMARY AND BACKGROUND (Page 14)

The following summary items are adapted from the regulation's preamble text. The order of the material is from the rule. We are providing page numbers (in red) to the items addressed below. In some cases more than one page reference is provided. The "higher" page number identifies the detailed section such material is discussed in the proposal.

OPPS Update: (Page 15) (Page 73) (816)
"For 2023, we propose to increase the payment rates under the OPPS by an Outpatient Department (OPD) fee schedule increase factor of 2.7 percent. This proposed increase factor is based on the proposed hospital inpatient market basket percentage increase of 3.1 percent for inpatient services paid under the hospital inpatient prospective payment system (IPPS) reduced by a proposed productivity adjustment of 0.4 percentage point."

Data used in CY 2023 OPPS/ASC Rate-setting: (Page 15)
CMS is proposing to use CY 2021 claims data with cost reports with cost reporting periods prior to the Public Health Emergency (PHE) to set CY 2023 OPPS and ASC payment system rates.

Partial Hospitalization Update: (Page 16) (383)
CMS proposes to calculate the Community Mental Health Center (CMHC) and hospital-based PHP (HB PHP) geometric mean per diem costs consistent, using the latest available CY 2021 claims data.

Changes to the Inpatient Only (IPO) List: (Page 16) (Page 407)
For 2023, CMS proposes to remove ten services from the Inpatient Only list.

340B-Acquired Drugs: (Page 16) (Page 345)
The Supreme Court ruled against CMS' methodology in paying for 340B drug acquisitions by hospitals.

CMS says "given the timing of the Supreme Court's decision, we were unable to adjust the proposed payment rates and budget neutrality calculations to account for that decision before issuing this proposed rule. For CY 2023, we are formally proposing a payment rate of ASP minus 22.5% for drugs and biologicals acquired through the 340B Program, consistent with our prior policy. But, we fully anticipate applying a rate of ASP plus 6% to such drugs and biologicals in the final rule for CY 2022."

CMS is interested in public comments on the best way to craft potential remedies affecting cost years 2018-2022 given that the Court did not resolve that issue.

Device Pass-Through Payment Applications: (Page 17) (Page 179)
CMS received 8 applications for device pass-through payments and solicits public comment. CMS will make final determinations on these applications in the CY 2023 OPPS/ASC final rule.

Cancer Hospital Payment Adjustment: (Page 17) (Page 86)
CMS proposes to continue providing additional payments to cancer hospitals so that a cancer hospital's payment-to-cost ratio (PCR) after the additional payments is equal to the weighted average PCR for the other OPPS hospitals using the most recently submitted or settled cost report data.

ASC Payment Update: (Page 17) (Page 490)
From 2019 through 2023 CMS adopted a policy to update the ASC payment system using the hospital market basket update. Using the hospital market basket methodology CMS proposes to increase payment rates under the ASC payment system by 2.7 percent for ASCs that meet the quality reporting requirements under the ASCQR Program. This proposed increase is based on a hospital market basket percentage increase of 3.1 percent

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reduced by a productivity adjustment of 0.4 percentage point. CMS estimates that total payments to ASCs (including beneficiary cost-sharing and estimated changes in enrollment, utilization, and case-mix) for CY 2023 would be approximately $5.4 billion, an increase of approximately $130 million compared to estimated CY 2022 Medicare payments.

Changes to the List of ASC Covered Surgical Procedures: (Page 18) (Page 491)
CMS proposes to add one procedure, a lymph node biopsy or excision, to the ASC Covered Procedures List (CPL) based upon existing criteria at § 416.166.

Hospital Outpatient Quality Reporting (OQR) Program: (Page 18) (Page 561)
For the Hospital OQR Program measure set, CMS is proposing to: (1) add a data validation targeting criterion to the existing four targeting criteria that reads: "Any hospital with a two-tailed confidence interval that is less than 75 percent, and that had less than four quarters of data due to receiving an ECE for one or more quarters," beginning with the CY 2023 reporting period/ CY 2025 payment determination; (2) align patient encounter quarters with the calendar year, beginning with the CY 2024 reporting period/ CY 2026 payment determination; and (3) change the Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (OP-31) Measure from Mandatory to Voluntary Beginning with the CY 2027 Payment Determination."

CMS is requesting comment on the future readoption of the Hospital Outpatient Volume on Selected Outpatient Surgical Procedures (OP-26) measure or another volume indicator in the Hospital OQR Program.

Ambulatory Surgical Center Quality Reporting (ASCQR) Program: (Page 18) (596)
For the ASCQR Program measure set, CMS is proposing to change the Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (ASC-11) Measure from Mandatory to Voluntary Beginning with the CY 2027 Payment Determination.

CMS is also requesting comment on: (1) the potential future implementation of a measures value pathways approach in the ASCQR Program; (2) the status and feasibility of interoperability initiatives in the ASCQR Program; and (3) the potential readoption of the ASC Facility Volume Data on Selected ASC Surgical Procedures (ASC-7) measure or another volume indicator in the ASCQR Program. CMS is also proposing to suspend mandatory implementation of the ASC-11 measure.

Organ Acquisition Payment Policy: (Page 19) (Page 652)
CMS is issuing a Request for Information on counting Medicare organs for use in calculating Medicare's share of organ acquisition costs. Also, CMS proposes to exclude research organs from the calculation of Medicare's share of organ acquisition costs and require a cost offset; these proposals CMS says would help ensure that Medicare does not share in the cost of research, and would lower the cost of procuring and providing research organs to the research community. Finally, CMS proposes to cover as organ acquisition costs certain hospital costs typically incurred when donors die from cardiac death, to promote organ procurement and enhance equity.

Rural Emergency Hospital (REH) Payment Polices: (Page 20) (Page 679)
Section 125 of the **Consolidated Appropriations Act** (CAA) established a new provider type called Rural Emergency Hospitals (REHs), effective January 1, 2023.

REHs are facilities that convert from either a critical access hospital (CAH) or a rural

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hospital (or one treated as such under section 1886(d)(8)(E) of the Social Security Act) with less than 50 beds, and that do not provide acute care inpatient services with the exception of posthospital extended care services furnished in a unit of the facility that is a distinct part licensed as a skilled nursing facility. By statute, REH services include emergency department services and observation care and, at the election of the REH, other outpatient medical and health services furnished on an outpatient basis, as specified by the Secretary through rulemaking.

By statute, covered outpatient department services provided by REHs will receive an additional 5.0 percent payment for each service. Beneficiaries will not be charged a copayment on the additional 5.0 percent payment.

CMS is proposing to consider all covered outpatient department services, other than inpatient hospital services as described in section 1833(t)(1)(B)(ii), that would otherwise be paid under the OPPS as REH services. CMS is also proposing that REHs may provide outpatient services that are not otherwise paid under the OPPS (such as services paid under the Clinical Lab Fee Schedule) as well as post-hospital extended care services furnished in a unit of the facility that is a distinct part of the facility licensed as a skilled nursing facility; however, these services would not be considered REH services and therefore would be paid under the applicable fee schedule and would not receive the additional 5.0 percent payment increase that CMS proposes to apply to REH services.

Finally, CMS is proposing that REHs would also receive a monthly facility payment. After the initial payment is established in CY 2023, the payment amount will increase in subsequent years by the hospital market basket percentage increase.

Rural Emergency Hospital Quality Reporting (REHQR) Program: (Page 19) (Page 625)
Section 1861(kkk)(7) of the Social Security Act, as added by section 125(a)(1)(B) of Division CC of the ***Consolidated Appropriations Act*** (CAA), requires the Secretary to establish quality measurement reporting requirements for Rural Emergency Hospitals (REHs).

CMS is seeking comment on several measures under consideration, as well as on topics of interest for the REHQR Program for future rulemaking, including rural behavioral/mental health, rural maternal health, and rural telehealth services.

CMS is also proposing that in order for REHs to participate in the REHQR Program, they must have an account with the Hospital Quality Reporting (HQR) secure portal and a designated Security Official.

Rural Emergency Hospitals (REH): Provider Enrollment: (Page 19) (Page 726)
Providers and suppliers are required to enroll in Medicare to receive payments for services and items furnished to Medicare beneficiaries. The purpose of the provider enrollment process is to help confirm that providers and suppliers seeking to bill Medicare meet all federal and state requirements to do so. This proposed rule would update existing Medicare provider enrollment regulations in 42 CFR Part 424, subpart P, to address enrollment requirements for REHs. One of the most important REH enrollment provisions is that the facility may submit a Form CMS-855A change of information application (rather than an initial enrollment application) in order to convert from a Critical Care Hospital (CAH) to an REH.

Rural Emergency Hospitals (REH) Physician Self-Referral Law Update: (Page 19) (Page 732)

continued

CMS proposes (1) a new exception for ownership or investment interests in an REH; and (2) revisions to certain existing exceptions to make them applicable to compensation arrangements to which an REH is a party.

Overall Hospital Quality Star Ratings: (Page 20) (Page 781)
CMS is (1) providing information on the previously finalized policy for inclusion of quality measure data from Veteran's Health Administration hospitals; (2) proposing to amend § 412.190(c) to state the use of publicly available measure results on Hospital Compare or its successor websites from a quarter within the prior 12 months (instead of the "prior year"); and (3) conveying that although CMS intends to publish Overall Hospital Quality Star Ratings in 2023, it may apply the suppression policy discussed in the CY 2021 OPPS/ASC proposed rule should data analysis demonstrate that the COVID-19 Public Health Emergency (PHE) substantially affects the underlying measure data.

Proposed Addition of a New Service Category for Hospital Outpatient Department Prior Authorization Process: (Page 21) (Page 773)
CMS proposes to add facet joint interventions as a category of services to the prior authorization process for hospital outpatient departments beginning for dates of service on or after March 1, 2023.

Mental Health Services Furnished Remotely by Hospital Staff to Beneficiaries in Their Homes: (Page 21) (Page 416)
For CY 2023, CMS is proposing to consider mental health services furnished remotely by hospital staff using communications technology to beneficiaries in their homes as covered outpatient department services payable under the OPPS and would create OPPS-specific coding for these services. CMS is proposing to require an in-person service within 6 months prior to the initiation of the remote service and then every 12 months thereafter, that exceptions to the in-person visit requirement may be made based on beneficiary circumstances (with the reason documented in the patient's medical record), and that more frequent visits are also allowed under this policy, as driven by clinical needs on a case-by-case basis.

CMS is also proposing that audio only interactive telecommunications systems may be used to furnish these services in instances where the beneficiary is not capable of, or does not consent to, the use of two-way, audio/video technology.

Supervision by Nonphysician Practitioners of Hospital and CAH Diagnostic Services Furnished to Outpatients: (Page 22)
To improve clarity, CMS proposes to replace cross references at § 410.27(a)(1)(iv)(A) and (B) and § 410.28(e) to the definitions of general and personal supervision at § 410.32(b)(3)(i) and (iii) with the text of those definitions. CMS also proposes to revise § 410.28(e) to clarify that certain nonphysician practitioners (nurse practitioners, physician assistants, clinical nurse specialists and certified nurse midwifes) may supervise the performance of diagnostic tests to the extent they are authorized to do so under their scope of practice and applicable State law.

Exemption of Rural Sole Community Hospitals (SCH) from the Method to Control Unnecessary Increases in the Volume of Clinic Visit Services Furnished in Excepted Off-Campus Provider-Based Departments (PBDs): (Page 22) (Page 381)
CMS is proposing to exempt rural Sole Community Hospitals (rural SCHs) from the site-specific Medicare Physician Fee Schedule (PFS)-equivalent payment for the clinic visit service, as described by HCPCS code G0463, when provided at an

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off-campus PBD excepted from section 1833(t)(21) of the Act (departments that bill the modifier "PO" on claim lines).

Proposed Payment Adjustments under the IPPS and OPPS for Domestic NIOSH Approved Surgical N95 Respirators: (Page 22) (Page 813)
CMS is proposing to provide payment adjustments to hospitals under the IPPS and OPPS for the additional resource costs they incur to acquire domestic NIOSH-approved surgical N95 respirators. These surgical respirators, which faced severe shortage at the onset of the COVID-19 pandemic, are essential for the protection of beneficiaries and hospital personnel that interface with patients. CMS is proposing that the payment adjustments would commence for cost reporting periods beginning on or after January 1, 2023.

II. UPDATES AFFECTING OPPS PAYMENTS (Page 32)

A. Recalibration of APC Relative Payment Weights (Page 33)
Calculation of Single Procedure APC Criteria-Based Costs (Page 39)

Blood and Blood Products (Page 39)

CMS proposes to continue to establish payment rates for blood and blood products using its blood-specific CCR methodology.

Brachytherapy Sources (Page 41)

CMS will maintain the CY 2019 payment rate of $4.69 per mm^2 for HCPCS code C2645.

CMS is proposing to designate 4 brachytherapy APCs as Low Volume APCs for CY 2023 as these APCs meet the criteria to be designated as a Low Volume APC.

Comprehensive APCs (C-APCs) for CY 2023 (Page 44)
Addendum J includes the cost statistics for each code combination that would qualify for a complexity adjustment (including primary code and add-on code combinations). (Page 53)

CMS proposes to add one C-APC under the existing C-APC payment policy in CY 2023: Proposed C-APC 5372 (Level 2 Urology and Related Services). (Page 57)

The rule's Table 1 (Page 58) lists the 70 C-APCs for CY 2023, including C-APC 5372 above.

Exclusion of Drugs and Biologicals Described by HCPCS Code C9399 (Unclassified drugs or biologicals) from the C-APC Policy (Page 55)
In order to ensure payment for new drugs, biologicals, and radiopharmaceuticals described by HCPCS code C9399 at 95 percent of their AWP, for CY 2023 and subsequent years, CMS proposes to exclude any drug, biological, or radiopharmaceutical described by HCPCS code C9399 from packaging when the drug, biological, or radiopharmaceutical is included on a claim with a "J1" service, which is the status indicator assigned to a C-APC, and a claim with a "J2" service, which is the status indicator assigned to comprehensive observation services.

Calculation of Composite APC Criteria-Based Costs
The rule's Table 2 (Page 64) lists the HCPCS codes that will be subject to the multiple imaging composite APC policy and their respective families and approximate composite APC final geometric mean costs for CY 2023.

Changes to Packaged Items and Services (Page 68)
For CY 2023, CMS is not proposing any changes to the overall packaging policy. However, CMS is proposing to increase the payment threshold from $130 to $135.

continued

B. Proposed Conversion Factor (CF) (Page 77)

CMS proposes a conversion factor of **$86.785** calculated as (1) the proposed OPD fee schedule increase factor of 2.7 percent for CY 2023, (2) a required proposed wage index budget neutrality adjustment of approximately 1.0010, (3) the proposed 0.5 percent annual cap for individual hospital wage index reductions adjustment of approximately 0.9995, (4) the proposed cancer hospital payment adjustment of 1.0000, (5) the proposed adjustment to account for the 0.01 percentage point of OPPS spending associated with the payment adjustment for domestic NIOSH-approved surgical N95 respirators, and (6) the proposed adjustment of an increase of 0.34 percentage point of projected OPPS spending for the difference in pass-through spending.

CMS proposes to use a reduced conversion factor of **$85.093** in the calculation of payments for hospitals that fail to meet the Hospital OQR Program requirements (a difference of -1.692 in the conversion factor relative to hospitals that met the requirements).

COMMENT

CMS does not provide calculation formulas for the CF; just the above narratives.

C. Wage Index Changes (Page 78)

The OPPS labor-related share remains at 60 percent of the national OPPS payment.

CMS proposes to use the FY 2023 IPPS post-reclassified wage index for urban and rural areas as the wage index for the OPPS to determine the wage adjustments for both the OPPS payment rate and the copayment rate for CY 2023. (Page 81)

D. Statewide Average Default CCRs (Page 84)

CMS will calculate the default ratios for CY 2023 using the June 2020 HCRIS cost reports.

E. Proposed Adjustment for Rural Sole Community Hospitals (SCHs) and Essential Access Community Hospitals (EACHs) under Section 1833(t)(13)(B) of the Act for CY 2023 (Page 85)

For CY 2023, CMS proposes to continue the current policy of a 7.1 percent payment adjustment for rural SCHs, including EACHs, for all services and procedures paid under the OPPS, excluding separately payable drugs and biologicals, brachytherapy sources, items paid at charges reduced to costs, and devices paid under the pass-through payment policy, applied in a budget neutral manner.

F. Proposed Payment Adjustment for Certain Cancer Hospitals for CY 2023 (Page 91)

The rule's Table 4 shows the proposed estimated percentage increase in OPPS payments to each of the 11 eligible cancer hospital for CY 2023.

G. Proposed Hospital Outpatient Outlier Payments (Page 91)

CMS sets the projected target for aggregate outlier payments at 1.0 percent of the estimated aggregate total payments under the OPPS for the prospective year. CMS estimates that the aggregate outlier payments for CY 2022 would be approximately 1.07 percent of the total CY 2022 OPPS payments.

CMS is setting the outlier threshold that exceeds 1.75 times the APC payment amount and exceeds the APC payment amount plus **$8,350.** The current threshold is $6,175.

For CMHCs, the threshold would be 3.40 times the payment rate, and the outlier payment will be calculated as 50 percent of the amount by which the cost exceeds 3.40 times APC 5853.

continued

H. Proposed Calculation of an Adjusted Medicare Payment from the National Unadjusted Medicare Payment (Page 96)
The national unadjusted payment rate for most APCs are contained in Addendum A and for most HCPCS codes to which separate payment under the OPPS has been assigned are in Addendum B.

III. OPPS AMBULATORY PAYMENT CLASSIFICATION (APC) GROUP POLICIES (Page 106)

A. Proposed OPPS Treatment of New CPT and Level II HCPCS Codes
CMS recognizes the following codes on OPPS claims:

Category I CPT codes, which describe surgical procedures, diagnostic and therapeutic services, and vaccine codes;
Category III CPT codes, which describe new and emerging technologies, services, and procedures;
MAAA CPT codes, which describe laboratory multianalyte assays with algorithmic analyses (MAA);
PLA CPT codes, which describe proprietary laboratory analyses (PLA) services; and
Level II HCPCS codes (also known as alpha-numeric codes), which are used primarily to identify drugs, devices, supplies, temporary procedures, and services not described by CPT codes.

The following reflects CMS' treatment of new codes added during the year.

April 2022 HCPCS Codes
For the April 2022 update, 48 new HCPCS codes were established and made effective on April 1, 2022. These codes and their long descriptors are listed in the rules' Table 5. (Page 109)

July 2022 HCPCS Codes
For the July 2022 update, 63 new codes were established and made effective July 1, 2022. The codes and long descriptors are listed in the rule's Table 6. (Page 112)

October 2022 HCPCS Codes (Page 115)
For CY 2022, CMS is continuing its established policy of assigning comment indicator "NI" in Addendum B to those new HCPCS codes that become effective October 1 indicate that CMS is assigning them an interim status indicator, which is subject to public comment.

January 2023 HCPCS Codes (Page 116)
CMS will solicit comments on the new Level II HCPCS codes that will be effective January 1, 2023 in the CY 2023 OPPS/ASC final rule, thereby allowing CMS to finalize the status indicators and APC assignments for the codes in the CY 2024 OPPS/ASC.

CMS proposes to continue its established policy of assigning comment indicator "NI" in Addendum B to the CY 2023 OPPS/ASC final rule to the new HCPCS codes that will be effective January 1, 2023. (Page 116)

In Table 7 (Comment and Finalization Timeframes for New and Revised OPPS Related HCPCS Codes) CMS summarizes its current process for updating codes through the OPPS quarterly update *Change Requests* (CRs), seeking public comments of these codes under the OPPS. (Page 119)

B. Proposed OPPS Changes – Variations within APCs (Page 119)
The Act provides that, subject to certain exceptions, the items and services within an APC group cannot be considered comparable with respect to the use of resources if the highest cost for an item or service in the group is more than 2 times greater than the lowest cost for an item or service within the same group (referred to as the "2 times rule"). The statute authorizes the Secretary to make exceptions to the 2 times rule in unusual cases, such as low volume items and services. Table 8 (Page 124) lists the 23 APCs that CMS proposes to exempt from the 2 times rule for CY 2023

continued

C. Proposed New Technology APCs
(Page 124)
a. Administration of Subretinal Therapies Requiring Vitrectomy (APC 1562)
(Page 134)

CMS proposes to assign HCPCS code C9770 to APC 1562 for CY 2023. The payment rate falls within the cost band for New Technology APC 1562 (New Technology—Level 25 ($3501–$4000)).

b. Bronchoscopy with Transbronchial Ablation of Lesion(s) by Microwave Energy
(Page 136)

CMS proposes to continue to assign HCPCS code C9751 to APC 1562 (New Technology—Level 25 ($3501–$4000)), with a proposed payment rate of $3,750.50 for CY 2023. Details regarding HCPCS code C9751 are included in Table 11. (Page 137)

c. Cardiac Positron Emission Tomography (PET)/Computed Tomography (CT) Studies (APCs 1522 & 1523 (Page 137)

CMS proposes to use CY 2021 claims data to determine the payment rates for CPT codes 78431, 78432, and 78433.

The geometric mean for CPT code 78431 was approximately $2,509, which is an amount that is above the cost band for APC 1522 (New Technology—Level 22 ($2001–$2500)), where the procedure is currently assigned. CMS proposes, for CY 2023, that CPT code 78431 be reassigned to APC 1523 (New Technology—Level 23 ($2501–$3000)) with a payment rate of $2,750.50. (Page 138)

CMS proposes, for CY 2023, to assign CPT code 78432 to APC 1520 (New Technology - Level 20 ($1801-$1900)) with a payment rate of $1,850.50. Please refer to Table 12 for the proposed on New Technology APC and status indicator assignments for CPT code 78432. (Page 138)

CMS proposes, for CY 2023, that CPT code 78433 be reassigned to APC 1521 (New Technology - Level 21 ($1901-$2000)) with a payment rate of $1,950.50. Refer to Table 12 for the proposed New Technology APC and status indicator assignments for CPT code 78433. (Page 139)

d. V-Wave Medical Interatrial Shunt Procedure (Page 1141)

For CY 2023, there were no claims from CY 2021 billed with HCPCS code C9758. Because there are no claims reporting HCPCS code C9758, CMS is proposing to continue to assign HCPCS code C9758 to New Technology APC 1590 with a payment rate of $17,500.50 for CY 2023.

e. Corvia Medical Interatrial Shunt Procedure (Page 141)

CMS propose to continue to assign HCPCS code C9760 to New Technology APC 1592. The proposed New Technology APC and status indicator assignments for HCPCS code C9760 are shown in Table 14.

f. Supervised Visits for Esketamine Self-Administration (APC codes 1512 and 1516)
(Page 143)

For CY 2023, CMS proposes to use CY 2021 claims data to determine the payment rates for HCPCS codes G2082 and G2083. Therefore, CMS proposes to assign these two HCPCS codes to New Technology APCs based on the codes' geometric mean costs. Assigning HCPCS code G2082 to New Technology APC 1511 (New Technology - Level 11 ($901 - $1000)) based on its geometric mean cost of $995.47. And, proposing to assign HCPCS code G2083 to New Technology APC 1516 (New Technology - Level 16 ($1401 - $1500)) based on its geometric mean cost of $1,489.93.

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g. DARI Motion Procedure (APC 1505) (Page 145)
CMS will continue to assign CPT code 0693T to New Technology APC 1505 (New Technology – Level 5 ($301 - $400)), for CY 2023.

h. Histotripsy Service (APC 1575) (Page 147)
CMS will continue to assign CPT code 0686T to APC 1575 for CY 2023.

i. Liver Multiscan Service (APC 1511) (Page 148)
CMS will continue to assign CPT code 0648T to New Technology APC 1511 ((New Technology- Level 11 ($901 - $1000), for CY 2023.

j. Minimally Invasive Glaucoma Surgery (MIGS) (APC 1526) (Page 149)
CMS proposes to continue assigning CPT codes 66989 and 66991 to New Technology APC 1526 for CY 2023. The proposed New Technology APC and status indicator assignments for CPT codes 66989 and 66991 are found in Table 19.

k. Scalp Cooling (APC 1520) (Page 151)
CPT code 0662T (Scalp cooling, mechanical; initial measurement and calibration of cap) became effective on July 1, 2021 to describe initial measurement and calibration of a scalp cooling device for use during chemotherapy administration to prevent hair loss.

For CY 2023, CMS proposes to continue assigning CPT code 0662T to New Technology APC 1520. The proposed New Technology APC and status indicator assignments for CPT code 0662T are found in Table 20.

l. Optellem Lung Cancer Prediction (LCP) (APC 1508) (Page 152)
CMS proposes to continue to assign CPT code 0721T to New Technology APC 1508 with a status indication of "S". The proposed New Technology APC and status indicator assignments for CPT code 0721T are found in Table 21.

m. Quantitative Magnetic Resonance Cholangiopancreatography (QMRCP) (APC 1511) (Page 152)
CMS proposes to continue to assign CPT code 0723T to New Technology APC 1511 with a status indicator of "S". The proposed New Technology APC and status indicator assignments for CPT code 0723T are found in Table 22.

n. CardiAMP (APC 1574) (Page 154)
CMS proposes to assign HCPCS code C9782 to New Technology APC 1590 with a status indication of "T". The proposed New Technology APC and status indicator assignments for HCPCS code C9782 are found in Table 23.

D. Universal Low Volume APC Policy for Clinical and Brachytherapy APCs (Page 156)
In the CY 2022 OPPS/ASC final rule CMS finalized its proposal to designate clinical and brachytherapy APCs as low volume APCs if they have fewer than 100 single claims that can be used for rate-setting purposes in the claims year used for rate-setting for the prospective year.

The rule's Table 24 includes the APC geometric mean cost without the low volume APC designation, that is, if CMS calculated the geometric mean cost based on CY 2021 claims data available for rate-setting; the median, arithmetic mean, and geometric mean cost using up to four years of claims data based on the APCs' designation as a low volume APC; and the statistical methodology CMS is proposing to use to determine the APC's cost for rate-setting purposes for CY 2023.
There 8 such APCS – 2631, 2635, 2636, 2647, 5244, 5494, 5495 and 5881. (Page 158)

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E. OPPS APC-Specific Policies (Page 158)
CMS has identified the following specific APC policies. They are listed below.
Fractional Flow Reserve Derived from Computed Tomography (FFRCT) (APC 5724) (Page 158)
Neurostimulator and Related Procedures (APCs 5461 Through 5465) (Page 162)
Urology and Related Services (APCs 5371 through 5378) (Page 165)
Unlisted Dental Procedure/Service (APC 5871) (Page 168)
COVID-19 Vaccine and Monoclonal Antibody Administration Services (Page 169) – For CY 2023,

CMS is proposing to continue to pay $40 per dose for the administration of the COVID–19 vaccines provided in the HOPD setting, and an additional $35.50 for the administration of the COVID-19 vaccines when provided under certain circumstances in the patient's home. (Page 174)

IV. OPPS PAYMENT FOR DEVICES (Page 179)

A. Proposed Pass-Through Payment for Devices

Expiration of Transitional Pass-Through Payments for Certain Devices (Page 180)

Currently, there are 11 device categories eligible for pass-through payment. These devices are listed in table below where CMS details the expiration dates of pass-through payment status.

HCPCS Codes	Long Descriptor	Effective Date	Pass-Through Expiration Date
C1823	Generator, neurostimulator (implantable), non-rechargeable, with transvenous sensing and stimulation leads	1/1/2019	12/31/2022
C1824	Generator, cardiac contractility modulation (implantable	1/1/2020	12/31/2022
C1982	Catheter, pressure-generating, one-way valve, intermittently occlusive	1/1/2020	12/31/2022
C1839	Iris prosthesis	1/1/2020	12/31/2022
C1734	Orthopedic/device/drug matrix for opposing bone-to-bone or soft tissue-to bone (implantable)	1/1/2020	12/31/2022
C2596	Probe, image-guided, robotic, waterjet ablation	1/1/2020	12/31/2022
C1748	Endoscope, single-use (that is, disposable), Upper GI, imaging/illumination device (insertable)	7/1/2020	6/30/2023
C1052	Hemostatic agent, gastrointestinal, topical	1/1/2021	12/31/2023
C1062	Intravertebral body fracture augmentation with implant (e.g., metal, polymer)	1/1/2021	12/31/2023
C1825	Generator, neurostimulator (implantable), nonrechargeable with carotid sinus baroreceptor stimulation lead(s)	1/1/2021	12/31/2023
C1761	Catheter, transluminal intravascular lithotripsy, coronary	7/1/2021	6/30/2024

continued

2. New Device Pass-Through Applications (Page 182)

CMS says it received "nine" complete applications by the March 1, 2022 quarterly deadline. (Page 186)

CMS received two application based on the Alternative Pathway Device Pass-through Application process: (Page 187)

They are:

aprevo™ Intervertebral Body Fusion Device (Page 187) and MicroTransponder® ViviStim® Paired Vagus Nerve Stimulation (VNS) System (Vivistim® System) (Page 193)

2. Traditional Device Pass-through Applications (Page 201)

CMS received the following traditional device pass-through devices. They are;

(1) The BrainScope TBI (model: Ahead 500) (Page 201)
(2) NavSlim™ and NavPencil (Page 218)
(3) SmartClip™ (Page 231)
(4) Evoke® Spinal Cord Stimulation (SCS) System (Page 247)
(5) Pathfinder® Endoscope Overtube (Page 262)
(6) The Uretero1 (Page 278)

COMMENT

CMS says it received 9 applications for device pass-throughs. Sorry, to me 2 plus 6 equals 8.

B. Proposal to Publicly Post OPPS Device Pass-through Applications (Page 291)
"To increase transparency, enable increased interested party engagement, and further improve and streamline our evaluation process, we propose to publicly post future applications for OPPS device pass-through payment online. Specifically, beginning with applications submitted on or after January 1, 2023, we propose to post online the completed OPPS device pass-through application forms and related materials (e.g., attachments, supportive materials) we receive from applicants. Additionally, we propose to post online information acquired subsequent to the application submission (e.g., updated application information, additional clinical studies, etc.). We propose that we would publicly post all completed application forms and related materials at the same time that the proposed rule is issued, which would afford interested parties the full public comment period to review the information provided by the applicant in its application in conjunction with the proposed rule. We are not proposing to change our policy that applicants whose applications are not approved through the quarterly review process may elect to withdraw their application from consideration in the next applicable rulemaking cycle."

C. Proposed Device-Intensive Procedures (Page 298)
CMS proposes to use CY 2021 claims information for determining device offset percentages and assigning device-intensive status. The full listing of the proposed CY 2023 device-intensive procedures can be found in Addendum P.

V. OPPS PAYMENT CHANGES FOR DRUGS, BIOLOGICALS, AND RADIOPHARMACEUTICALS (Page 309)

A. OPPS Transitional Pass-Through Payment for Additional Costs of Drugs, Biologicals, and Radiopharmaceuticals
1. Drugs and Biologicals with Expiring Pass-Through Payment Status in CY 2022 (Page 312)

continued

There are 32 drugs and biologicals for which pass-through payment status expires on December 31, 2022 or for which the equitable adjustment to mimic continued pass-through payment will end on December 31, 2022, as listed in Table 39. (Page 314)

The packaged or separately payable status of each of these drugs or biologicals is listed in Addendum B.

2. Drugs, Biologicals, and Radiopharmaceuticals with Pass-Through Payment Status Expiring in CY 2023. (Page 316)

There are 43 drugs and biologicals for which pass-through payment status will expire in CY 2023. They are shown in the rule's Table 40. (Page 318)

3. *Drugs, Biologicals, and Radiopharmaceuticals with Pass-Through Payment Status Continuing in CY 2023.* (Page 322)

The drugs and biologicals that CMS proposes would have pass-through payment status expire after December 31, 2023, are shown in the rule's Table 41. (Page 324)

B. Proposed OPPS Payment for Drugs, Biologicals, and Radiopharmaceuticals Without Pass-Through Payment Status (Page 329)

Proposed Packaging Threshold

The packaging threshold for CY 2023 is being proposed at **$135**, an increase of the current threshold of $130.

CY 2023 OPPS Payment Methodology for 340B Purchased Drugs (Page 345)

Beginning in CY 2018, the Secretary adjusted the 340B drug payment rate to ASP minus 22.5 percent to approximate a minimum average discount for 340B drugs, which was based on findings of the GAO and MedPAC that hospitals were acquiring drugs at a significant discount under HRSA's 340B Drug Pricing Program.

This policy has been the subject of significant litigation, recently culminating in the Supreme Court's decision in American Hospital Association v. Becerra, No. 20-1114, 2022 WL 2135490 (June 15, 2022). CMS says that "given the timing of the Supreme Court's decision, we lacked the necessary time to incorporate the adjustments to the proposed payment rates and budget neutrality calculations to account for that decision before issuing this proposed rule." (Page 347)

For that reason alone, the payment rates, tables, and addenda in this proposed rule reflect a payment rate of ASP minus 22.5 percent for drugs and biologicals acquired through the 340B program for CY 2023.

CMS notes that it "fully anticipates applying a rate of ASP+6 percent to such drugs and biologicals in the final rule for CY 2023." Further, CMS says it is still evaluating how to apply the Supreme Court's recent decision to prior cost years.

CMS says "to ensure budget neutrality under the OPPS, after applying this alternative payment methodology for drugs and biologicals purchased under the 340B Program, we currently estimate that we would apply an offset of approximately $1.96 billion to decrease the OPPS conversion factor, which would result in a budget neutrality adjustment of 0.9596 to the OPPS conversion factor, for a revised conversion factor of **$83.279.**" (Page 353)

High Cost/Low-Cost Threshold for Packaged Skin Substitutes (Page 354)

The proposed CY 2023 mean unit cost (MUC) threshold is $47 per cm^2 (rounded

continued

to the nearest $1) and the proposed CY 2023 per day cost (PDC) threshold is $837 (rounded to the nearest $1). (Page 357)

For CY 2023, CMS proposes to delete HCPCS code C1849 (Skin substitute, synthetic, resorbable, by per square centimeter). CMS also proposes that any graft skin substitute product that is currently assigned a product-specific code in the HCPCS A2XXX series and is appropriately described by HCPCS code C1849 or is assigned a product-specific code in the HCPCS A2XXX series in the future and is appropriately described by HCPCS code C1849 be assigned to the high-cost skin substitute group. (Page 366)

VI. PROPOSED ESTIMATE OF OPPS TRANSITIONAL PASS-THROUGH SPENDING FOR DRUGS, BIOLOGICALS, RADIOPHARMACEUTICALS, AND DEVICES (Page 374)

Section 1833(t)(6)(E) of the Act limits the total projected amount of transitional pass-through payments for drugs, biologicals, radiopharmaceuticals, and categories of devices for a given year to an "applicable percentage," currently not to exceed 2.0 percent of total program payments estimated to be made for all covered services under the OPPS furnished for that year.

Therefore, CMS estimates that pass-through spending in CY 2023 will not amount to 2.0 percent of total projected OPPS CY 2022 program spending.

VII. OPPS PAYMENT FOR HOSPITAL OUTPATIENT VISITS AND CRITICAL CARE SERVICES (Page 381)

CMS will continue to utilize a Physician Fee Schedule (PFS)-equivalent payment rate for hospital outpatient clinic visit services described by HCPCS code G0463 when it is furnished by excepted off-campus provider-based departments. The PFS-equivalent rate for CY 2023 is 40 percent of the OPPS payment (that is, 60 percent less than the OPPS rate).

VIII. PAYMENT FOR PARTIAL HOSPITALIZATION SERVICES (Page 383)

A partial hospitalization program (PHP) is an intensive outpatient program of psychiatric services provided as an alternative to inpatient psychiatric care for individuals who have an acute mental illness, which includes, but is not limited to, conditions such as depression, schizophrenia, and substance use disorders.

The following table provides the CY 2023 values.

Proposed CY 2023 PHP APC Geometric Mean Per Diem Costs

CY 2023 APC	Group Title	Proposed PHP APC Geometric Mean Per Diem Costs
5853	Partial Hospitalization (3 or more services per day) for CMHCs	$131.71
5863	Partial Hospitalization (3 or more services per day) for hospital-based PHPs	$264.06

IX. PROPOSED SERVICES THAT WILL BE PAID ONLY AS INPATIENT SERVICES (Page 407)

In the CY 2021 OPPS/ASC final rule, CMS finalized its proposal to eliminate the IPO list over the course of three years. As part of the first phase of this elimination of the

continued

IPO list, CMS removed 298 codes from the list beginning in CY 2021.

CMS has identified 10 services described by the following codes that it proposes to remove from the IPO list for CY 2023: (Page 411)

CPT code 16036 (Escharotomy; each additional incision (list separately in addition to code for primary procedure));
CPT code 22632 (Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (list separately in addition to code for primary procedure));
CPT code 21141 (Reconstruction midface, lefort i; single piece, segment movement in any direction (eg, for long face syndrome), without bone graft);
CPT code 21142 (Reconstruction midface, lefort i; 2 pieces, segment movement in any direction, without bone graft);
CPT code 21143 (Reconstruction midface, lefort i; 3 or more pieces, segment movement in any direction, without bone graft);
CPT code 21194 (Reconstruction of mandibular rami, horizontal, vertical, c, or l osteotomy; with bone graft (includes obtaining graft));
CPT code 21196 (Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation);
CPT code 21347 (Open treatment of nasomaxillary complex fracture (lefort ii type); requiring multiple open approaches);
CPT code 21366 (Open treatment of complicated (eg, comminuted or involving cranial nerve foramina) fracture(s) of malar area, including zygomatic arch and malar tripod; with bone grafting (includes obtaining graft)); and
CPT code 21422 (Open treatment of palatal or maxillary fracture (lefort i type);)

The complete list of codes describing services that are designated as inpatient only services beginning in CY 2023 is also included as Addendum E.

The rule's table 46 (Page 414) contains the proposed changes to the IPO list for CY 2023.

X. NONRECURRING POLICY CHANGES (Page 416)

CMS addresses 9 non-recurring policy changes as noted below.

Mental Health Services Furnished Remotely by Hospital Staff to Beneficiaries in Their Homes (Page 416)
Comment Solicitation on Intensive Outpatient Mental Health Treatment, including Substance Use Disorder (SUD) Treatment Furnished by Intensive Outpatient Programs (IOPs) (Page 430)
Direct Supervision of Certain Cardiac and Pulmonary Rehabilitation Services by Interactive Communications Technology (Page 432)
Use of Claims Data for CY 2023 OPPS and ASC Payment System Rate-setting Due to the PHE (Page 434)
Supervision by Nonphysician Practitioners of Hospital and CAH Diagnostic Services Furnished to Outpatients (Page 440)
Coding and Payment for Category B Investigational Device Exemption Clinical Devices and Studies (Page 443)
OPPS Payment for Software as a Service (Page 449)
Proposed Payment Adjustments under the IPPS and OPPS for Domestic NIOSH-Approved Surgical N95 Respirators (Page 459)

Proposal to Exempt Rural Sole Community Hospitals from the Method to Control Unnecessary Increases in the Volume of Clinic Visit Services Furnished in Excepted Off-Campus Provider-Based Departments (PBDs) (Page 477)

continued

XI. PROPOSED CY 2023 OPPS PAYMENT STATUS AND COMMENT INDICATORS (Page 486)

For CY 2023, CMS proposes to revise the definition of status indicator "A" to include unclassified drugs and biologicals that are reportable under HCPCS code C9399.

CMS proposes to revise the definition of status indicator "F" by removing hepatitis B vaccines.

The complete list of proposed CY 2023 payment status indicators and their definitions is displayed in Addendum D1.

XII. PROPOSED UPDATES TO THE AMBULATORY SURGICAL CENTER (ASC) PAYMENT SYSTEM (Page 490)

Proposed Calculation of the ASC Payment Rates and the ASC Conversion Factor (Page 559)

For CY 2023, CMS proposes to adjust the CY 2022 ASC conversion factor ($49.916) by the proposed wage index budget neutrality factor of 1.0010 in addition to the productivity-adjusted hospital market basket update of 2.7 percent, which results in a proposed CY 2023 ASC conversion factor of **$51.315** for ASCs meeting the quality reporting requirements. The current CF is $49.916.

For ASCs not meeting the quality reporting requirements, CMS proposes to adjust the CY 2022 ASC conversion factor by the proposed wage index budget neutrality factor of 1.0010 in addition to the quality reporting/productivity-adjusted hospital market basket update of 0.7 percent, which results in a proposed CY 2023 ASC conversion factor of $50.315.

The proposed payment rates included in Addenda AA and BB reflect the full ASC proposed payment update and not the reduced payment update used to calculate payment rates for ASCs not meeting the quality reporting requirements under the ASCQR Program.

Treatment of New and Revised Codes (Page 494)

April 2022 HCPCS Codes (Page 495)

For the April 2022 update, there were no new CPT codes but, there were several new Level II HCPCS codes.

The rule's Table 53 lists the new Level II HCPCS codes implemented April 1, 2022, along with their payment indicators for CY 2023.

July 2022 HCPCS Codes (Page 497)

The rule's Table 52 (New Level II HCPCS Codes for Ancillary Services Effective July 1, 2022) lists the new HCPCS codes that are effective July 1, 2022.

CMS added three new Category III CPT codes effective July 1, 2022. These codes are listed in Table 53 (New Category III CPT Codes for Covered Ancillary Services Effective July 1, 2022).

October 2022 HCPCS Codes (Page 499)

For CY 2023, the Level II HCPCS codes that became effective October 1, 2022, are flagged with comment indicator "NI" in Addendum BB to indicate that CMS has assigned the codes on an interim OPPS payment status for CY 2022.

January 2023 HCPCS Codes (Page 499)

These codes are listed in Addendum AA and Addendum BB with short descriptors only, CMS is listing them again in Addendum O with the long descriptors.

continued

Proposed Changes for CY 2023 to Covered Surgical Procedures Designated as Office-Based (Page 499)

The CPT codes that CMS proposes to permanently designate as office-based for CY 2023 are listed in the rule's Table 55. (Page 505)

Proposed Changes to List of ASC Covered Surgical Procedures Designated as Device-Intensive for CY 2023 (Page 507)

The ASC covered surgical procedures being proposed as device-intensive, and therefore subject to the device-intensive procedure payment methodology for CY 2023, are assigned payment indicator "J8" and are included in ASC Addendum AA.

Proposed Changes to the List of ASC Covered Surgical Procedures for CY 2023 (Page 514)

CMS proposes to update the ASC CPL by adding one lymphatic procedure to the list for CY 2023, as shown in the rule's Table 57.

ASC Payment System Policy for Non-Opioid Pain Management Drugs and Biologicals that Function as Surgical Supplies (Page 535)

The rule's table 60 lists the four drugs that CMS proposes to meet the criteria described at § 416.174 to receive separate payment as a non-opioid pain management drug that functions as a supply in a surgical procedure under the ASC payment system for CY 2023. (Page 545)

XIII. PROPOSED REQUIREMENTS FOR THE HOSPITAL OUTPATIENT QUALITY REPORTING (OQR) PROGRAM (Page 561)

CMS is proposing to change the Cataracts: Improvement in Patient's Visual Function within 90 Days
Following Cataract Surgery (OP-31) Measure from mandatory to voluntary beginning with the CY 2027 payment determination. (Page 564)

Refer to the introductory/ summary section of this analysis for the deletions and additions of final quality reporting measures. (Page 18)

Summary of Previously and Newly Finalized Hospital OQR Program Measure Set for the CY 2024 Payment Determination

The table below, summarizes the previously finalized Hospital OQR Program measure set for the CY 2024 payment determination and subsequent years. (Page 567)

Hospital OQR Program Measure Set for the CY 2024 Payment Determination

NQF #	Measure Name
0288	OP-2: Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival
0290	OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention
0514	OP-8: MRI Lumbar Spine for Low Back Pain
None	OP-10: Abdomen CT – Use of Contrast Material
0669	OP-13: Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low-Risk Surgery
0496	OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients
0499	OP-22: Left Without Being Seen
0661	OP-23: Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival
0658	OP-29: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

continued

NQF #	Measure Name
1536	OP-31: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery
2539	OP-32: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
None	OP-35: Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy
2687	OP-36: Hospital Visits after Hospital Outpatient Surgery
None	OP-38: COVID-19 Vaccination Coverage Among Health Care Personnel
None	OP-39: Breast Cancer Screening Recall Rates

Summary of Previously and Newly Finalized Hospital OQR Program Measure Set for the CY 2025 Payment Determination (Page 568)

Hospital OQR Program Measure Set for the CY 2025 Payment Determination

NQF #	Measure Name
0514	OP-8: MRI Lumbar Spine for Low Back Pain
None	OP-10: Abdomen CT – Use of Contrast Material
0669	OP-13: Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low-Risk Surgery
0496	OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients
0499	OP-22: Left Without Being Seen
0661	OP-23: Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival
0658	OP-29: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients
1536	OP-31: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery
2539	OP-32: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
None	OP-35: Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy
2687	OP-36: Hospital Visits after Hospital Outpatient Surgery
None	OP-37a: Consumer Assessment of Healthcare Providers and Systems Outpatient and Ambulatory Surgery Survey (OAS CAHPS) – About Facilities and Staff
None	OP-37b: OAS CAHPS – Communication About Procedure
None	OP-37c: OAS CAHPS – Preparation for Discharge and Recovery
None	OP-37d: OAS CAHPS – Overall Rating of Facility
None	OP-37e: OAS CAHPS – Recommendation of Facility
None	OP-38: COVID-19 Vaccination Coverage Among Health Care Personnel
None	OP-39: Breast Cancer Screening Recall Rates
None	OP-40: ST-Segment Elevation Myocardial Infraction (STEMI) electronic clinical quality measure (eCQM)

measures. (Page 18)

XIV. REQUIREMENTS FOR THE AMBULATORY SURGICAL CENTER QUALITY REPORTING (ASCQR) PROGRAM (Page 596)

Refer to the introductory/ summary section of this analysis for the deletions and additions of final quality reporting

ASCQR Program Measure Set for the CY 2023 Reporting Period/CY 2025 Payment Determination and the CY 2024 Reporting Period/CY 2026 Payment Determination (Page 600)

ASCQR Program Measure Set for the CY 2023 Reporting Period/CY 2025 Payment

continued

Determination and the CY 2024 Reporting Period/CY 2026 Payment Determination

ASC #	NQF #	Measure Name
ASC-1	0263	Patient Burn
ASC-2	0266	Patient Fall
ASC-3	0267	Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant
ASC-4	0265	All-Cause Hospital Transfer/Admission
ASC-9	0658	Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients
ASC-11	1536	Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery
ASC-12	2539	Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
ASC-13	None	Normothermia Outcome
ASC-14	None	Unplanned Anterior Vitrectomy
ASC-17	3470	Hospital Visits after Orthopedic Ambulatory Surgical Center Procedures
ASC-18	3366	Hospital Visits after Urology Ambulatory Surgical Center Procedures
ASC-19	3357	Facility-Level 7-Day Hospital Visits after General Surgery Procedures Performed at Ambulatory Surgical Centers
ASC-20	None	COVID-19 Vaccination Coverage Among Health Care Personnel

Summary of Previously and Newly Finalized ASCQR Program Quality Measure Set for the CY 2025 Reporting Period/CY 2027 Payment Determination (Page 602)

ASC #	NQF #	Measure Name
ASC-1	0263	Patient Burn
ASC-2	0266	Patient Fall
ASC-3	0267	Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant
ASC-4	0265	All-Cause Hospital Transfer/Admission
ASC-9	0658	Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients
ASC-11	1536	Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery
ASC-12	2539	Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
ASC-13	None	Normothermia Outcome
ASC-14	None	Unplanned Anterior Vitrectomy
ASC-15a	None	OAS CAHPS – About Facilities and Staff
ASC-15b	None	OAS CAHPS – Communication About Procedure
ASC-15c	None	OAS CAHPS – Preparation for Discharge and Recovery
ASC-15d	None	OAS CAHPS – Overall Rating of Facility
ASC-15e	None	OAS CAHPS – Recommendation of Facility
ASC-17	3470	Hospital Visits after Orthopedic Ambulatory Surgical Center Procedures
ASC-18	3366	Hospital Visits after Urology Ambulatory Surgical Center Procedures
ASC-19	3357	Facility-Level 7-Day Hospital Visits after General Surgery Procedures Performed at Ambulatory Surgical Centers
ASC-20	None	COVID-19 Vaccination Coverage Among Health Care Personnel*

continued

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting

COMMENT

The OQR and ASCQR sections contain much more information than the material presented here. Items addressed include potential future additions; the form, manner and timing of data submissions; and, extraordinary exceptions.

Other major sections of the proposal include the following. Please refer to the summary material at the beginning of this analysis for details.

Organ Acquisition Payment Policy (Page 652)

Requirements for the Rural Emergency Hospital Quality Reporting (REHQR) Program (Page 625)

Rural Emergency Hospitals (REH): Payment Policies, Conditions of Participation, Provider Enrollment, Use of the Medicare Outpatient Observation Notice, and physician ***Self-Referral Law Updates*** (Page 679)

Overall Hospital Quality Star Rating (Page 781)

FINAL THOUGHTS

As previously noted, this analysis does not include all material expressed in the rulemaking.

We have continuously noted CMS' serious absence of a total table of contents or the inclusion of one that simply identifies major heads or sections. Trying to follow CMS' logic of numbering within its rules is complicated and extremely time consuming. Once again, CMS needs to include a detailed table of contents in all its rulemaking. Further, CMS needs to more completely cite its sections within the body of the rule. Telling one this "a" and it follows with "b" is not very helpful. CMS needs to add the Section, for example "II." This needs to be followed with the major sub-section head, for example "A." Only then will items like "a" or "b" make sense to the reader.

The OPPS and ASC payment systems rely on extensive coding. The amount of coding changes are both extensive and will impact final payments.

CMS' continued historical information and time frames maybe helpful to some, but to most, it is simply overkill and a distraction. It adds significant unneeded verbiage. We believe most would like to see updates that simply focus on what is the current policy and to what is changing for the following year(s). Prior development is totally unnecessary.

CMS seems to follow outdated printed encyclopedias from 50 years ago where one purchased a set and then every year bought the annual update. These rules should not be a continuing historical learning tool inasmuch as much prior information has been superseded.