

CY 2021 Medicare Hospital Outpatient Prospective Payment System (OPPS) Final Rule Executive Summary
On December 2, 2020 the Centers for Medicare and Medicaid Services (CMS) released the Calendar Year (CY) 2021 Medicare Hospital Outpatient Prospective Payment System (OPPS) final rule (CMS-1736-F). Below is a high-level summary of key changes:

Proposed Changes to the Inpatient Only (IPO) List

- CMS is finalizing its proposal for a three-year transition to the complete elimination of the IPO list, beginning with a total of 298 services, including 266 musculoskeletal services, removed for CY 2021 (See Table 48) and complete elimination of all 1,740 services on the list by CY 2024.
- The 266 musculoskeletal services removed from the IPO for CY 2021 will be assigned to C-APCS listed in Table 48.
- Additional anesthesia codes that are billed with musculoskeletal services were also removed from the IPO in the final rule (See Table 46).
- CMS acknowledged concerns regarding the impact that elimination of the IPO will have on the volume and complexity of the case mix for the CJR, BPCI, and BPCI-Advanced models and states that CMMI will consider future changes to these models to address the IPO elimination.
- In response to feedback CMS will, in the future, provide informational guidance on appropriate site of service selection to support physician decision-making.
- CMS will apply offset calculations and assessment in determining device-intensive status at the HCPCS/CPT code level for procedures removed in CY 2021.
- CMS is finalizing the policy to continue the 2-year exemption from Beneficiary and Family-Centered Care Quality Improvement Organizations (BFCC-QIOs) referrals to Recovery Audit Contractors (RACs) and RAC reviews for “patient status” (otherwise known as site-of-service) for procedures removed from the IPO under the OPPS rule effective January 1, 2021.
- CMS is also finalizing a new policy to indefinitely extend the medical review exemption period for services removed from the IPO beginning in CY 2021.
This policy will remain in place until there is enough data to show that a procedure removed from the IPO is performed more commonly in the outpatient setting than the inpatient setting.
- CMS states that the 2-midnight benchmark will remain an essential metric to guide when Part A payment for inpatient hospital admissions is appropriate.
- CMS emphasizes in the final rule that certain services may still be paid for under Part A by using the 2-midnight benchmark or qualifying for the case-by-case exception to the 2-midnight benchmark.

Changes to the ASC Covered Procedure List (CPL)

- CMS is finalizing the addition of 11 procedures to the ASC CPL, **including total hip arthroplasty.**
(See Table 59 for complete list of the procedures proposed to be added to the ASC CPL).
- CMS is finalizing a proposal to update the process for adding procedures to the ASC CPL in which CMS reduces the number of general exclusion criteria for covered surgical procedures for the ASC payment system.
- The eliminated safety criteria will instead be displayed as considerations for physicians determining site of service.

- There will be four criteria to determine whether a procedure meets the regulatory requirements for addition to the ASC CPL: procedure is separately paid under the OPSS, not designated as requiring inpatient care under § 419.22(n) as of 12/31/2020, not only able to be reported using a CPT unlisted surgical procedure code, or not otherwise excluded under § 411.15
- Stakeholders may notify CMS if they believe a procedure meets the criteria and CMS will confirm whether it does, and subsequently add it to the ASC CPL.
- This finalized change will result in 267 surgery or surgery-like codes being added to the CPL that are not on the current IPO list (*See Table 60*).

Prior Authorization

- CMS is finalizing the addition of the following groups of services to the prior authorization list beginning on July 1, 2021: cervical fusion with disc removal and implanted spinal neurostimulators.
- This includes CPT codes 63685, 63688, 63650, 22551, and 22552 (*See Table 74*).

Physician-Owned Hospitals

- CMS is finalizing the removal of unnecessary restrictions on high Medicaid facilities and the inclusion of beds in a physician-owned hospital's baseline consistent with state law.
- CMS defines high Medicaid facilities as those "whose annual percent of total inpatient admissions under Medicaid is equal to or greater than the average percent with respect to such admissions for all hospitals in the county in which the hospital is located during the most recent 12-month period for which data are available", is not the only hospital in a county, and does not discriminate against beneficiaries of Federal health care programs.
- CMS is finalizing the proposal to allow high Medicaid facilities to request an exception to the facility expansion prohibition more frequently than once every 2 years, however the facility may only submit one exception request at a time.
- CMS is finalizing the proposal to lift the restriction that permitted expansion of facility capacity may not result in the number of operating rooms, procedure rooms, and beds for which the hospital is licensed increasing beyond 200 percent of the hospital's baseline number of these rooms, as well as lifting the restriction on facility expansion only in facilities on the hospital's main campus.

Overall Hospital Quality Star Ratings

- CMS is finalizing the proposal to establish and update the methodology used to calculate Overall Hospital Quality Star Ratings beginning in CY 2021 by updating and simplifying how the ratings are calculated, reducing the total number of measure groups.
- CMS is not finalizing the proposals for stratifying the Readmission measure group based on the proportion of dual-eligible patients.

OPSS Payment for Devices

- CMS determined that the SpineJack Expansion Kit meets the substantial clinical improvement criterion and approved the application for device pass-through payment status for the SpineJack Expansion Kit beginning in CY 2021.

OPPS Payment Changes for Drugs, Biologicals, and Radiopharmaceuticals

- CMS finalized ending pass-through payment status for 25 biologicals and drugs in CY 2021, which is one less than proposed. The difference comes from Rolapitant (J2797) being moved to the list of drugs with pass-through status expiring in CY 2020.
- The list of drugs with pass-through payment status expiring in CY 2021 can be found in Table 37 of the Final Rule.
- CMS finalized for policy-packaged drugs (anesthesia, biologicals) that the pass-through payment be equal to ASP+6 percent minus payment offset for the portion of the otherwise applicable OPD fee schedule that the Secretary determines is associated with the drug or biological as described in section V.A.6 of the proposed rule.

The complete rule can be found [here](#).

The tables referenced in the summary can be found [here](#).