NAHRI National Association of Healthcare Revenue Integrity

2023 OPPS final rule reduces some payments to offset restored 340B reimbursement

CMS finalized a higher-than-proposed payment increase that was almost erased for most non-drug services to offset ending reduced reimbursement for 340B drugs, according to the 2023 Outpatient Prospective Payment System (OPPS) final rule. Provisions of the rule, released November 1, also detail significant changes to payment for software as a service (SaaS) and behavioral and rural health programs, such as the rural emergency hospital (REH) designation, among other updates.

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Payment updates

Effective January 1, 2023, OPPS payments will increase by a net 3.8%, based on a market basket percentage increase of 4.1% with a 0.3% productivity reduction. This is higher than the 2.7% increase **CMS originally proposed** for 2023. However, it still isn't enough to keep pace with the extraordinary costs hospitals face, according to the American Hospital Association's **statement**.

340B drug program

After the **Supreme Court ruled** that CMS' 2018 cuts to the 340B drug discount program were unlawful, **experts speculated** on how the agency would address it in the 2023 OPPS final rule. One of the major questions was how CMS would maintain budget neutrality while restoring 340B reimbursement to average sales price (ASP) +6%.

CMS' answer is to implement a 3.09% reduction to payment rates for non-drug services for 2023. This is less than the 4.04% reduction the agency floated as one of its options in the 2023 OPPS proposed rule.

As for how CMS will address payment cuts for 2018–2022, that will be forthcoming in separate rulemaking. The agency intends to release its plan for a remedy before the 2024 OPPS proposed rule, according to the 2023 OPPS final rule.

Organizations will have to wait and see what CMS and the courts decide, says NAHRI Advisory Board member **Jugna Shah, MHP, CHRI**, president of Nimitt Consulting Inc., in Spicer, Minnesota. It's unclear what CMS will do and that makes it particularly urgent that organizations be ready to respond to proposals immediately.

"What is clear, however, is that providers must keep the heat up on this issue so that CMS remedies the past, rather than trying to explain why it doesn't have to," Shah says. "The other, more perplexing issue for me, [is] the mismatch between CMS' statement in response to the court's decision on September 28, 2022, and what the MACs are posting on their websites about what they can/cannot do vs. providers about requesting claim adjustment payments."

CMS has made it clear that claims for the rest of the year, on or after September 28, have to be paid at ASP +6%; however, that does not apply to claims prior to this date, Shah points out. Confusingly, several MACs appear to have guidance on their sites that indicate that a provider can initiate a request for a mass adjustment dating back to January 1, 2022, well before the court's decision.

"[This] seems wildly inconsistent with the rule and everything else that has come out on this issue," Shah says.

Prior authorization

Unsurprisingly, CMS finalized adding facet joint interventions to its hospital outpatient department prior authorization list. In response to feedback, CMS scrapped it's proposed March 1, 2023, effective date for this proposal. Instead, facet joint injection procedures will be subject to prior authorization starting July 1, 2023.

“Prior authorizations for joint injections will potentially affect providers not affected by the prior cosmetic or major back procedure requirements,” says **Kimberly A. Hoy, JC, CPC**, director of Medicare and compliance at HCPro in Brentwood, Tennessee. “CMS’ delay until July 1, 2023, in line with prior delays, rather than going forward March 1, 2023, will give providers needed time to prepare.”

CMS continues to cite the need to control unnecessary increases in volume as the deciding factor behind requiring prior authorization. CMS has seen a marked increase in the volume of facet joint injection procedures, so it’s not unreasonable for it to take steps to ensure they’re medically necessary, says NAHRI Advisory Board member **Ronald Hirsch, MD, FACP, CHCQM, CHRI**, vice president, regulations and education group with R1 RCM in Murray, Utah. Although prior authorization can be burdensome, it can help avoid at least some denials.

“From the provider side, it seems better to have the assurance of payment prior to performing the procedure instead of incurring the costs of performing the procedure and then being denied payment afterwards,” Hirsch says.

Behavioral health

CMS finalized its proposal to cover certain remote behavioral health services. Currently, OPPS-covered behavioral health services can only be provided remotely under the Hospitals Without Walls policy. However, the emergency waivers that made the policy possible are set to expire with the end of the COVID-19 public health emergency. Making coverage of these services when provided remotely part of the OPPS will avoid interruptions in care and improve access, according to CMS.

CMS’ guidance may represent a great opportunity to expand the mental health services provided by some hospitals or at least maintain those developed during the public health emergency, Hoy says.

Does this signal that CMS will make similar calls for remote medical services? That’s not clear. Although the benefits of covering remote behavioral health services have become abundantly clear, the same can’t be said of medical services, Hirsch points out. A **recent study** published in JAMA found that telehealth visits following emergency department (ED) visits were associated with more return visits to the ED and higher admissions.

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REHs

CMS is moving ahead with its proposal to establish a new provider type, the REH. Eligible facilities, such as critical access hospitals and small rural hospitals, will be able to switch to REHs on January 1, 2023. The final rule and **fact sheet** contain extensive details on payments for these provider types, covered services, and other requirements.

SaaS

CMS finalized its proposal to make separate payment for SaaS using add-on codes. The SaaS add-on codes will be assigned to identical ambulatory payment classifications and will be assigned to the same status indicator as their standalone codes.

Conclusion

Revenue integrity professionals should read the final rule and **fact sheet** thoroughly. Identify the provisions that will affect your organization, your department, and any specific workflows or internal policies. Ensure staff in your department are aware of the final rule, and reach out to colleagues in other departments, such as coding, compliance, or finance, to alert them and discuss the changes. Develop education and make sure any affected systems or processes are updated.

Most provisions of the final rule will be effective January 1, 2023. Prioritize tasks and set deadlines to ensure that your organization will be in compliance by that date.

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