Top 5 Takeaways
From the Medicare Final Outpatient Rule for 2021

The Centers for Medicare & Medicaid Services (CMS) issued the final outpatient prospective payment system rule on December 2, 2020. While the year-end final rules are usually out by November 1, CMS was delayed in issuing many final rules this year due to COVID. With the delay, providers have only until January 1 to make any needed system changes in order to assure compliance. A few provisions of the final rule are outlined below:

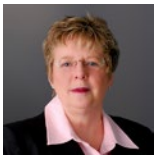
1. The conversion factor for CY2021 is $82.797, a 2.4 percent increase over the CY2020 rate.

2. The outlier threshold is increased from $5,075 (CY2020) to $5,300 for CY2021.
   - The proposed rule called for a change in the payment for 340B drugs, from Average Sales Price (ASP) minus 22.5 percent to ASP minus 28.7 percent. The final rule did not make this change, but rather kept the rate at ASP minus 22.5 percent.

3. The Inpatient Only List (IOL) will be eliminated over three years. CMS believes that the decision as to whether a patient should be an inpatient or an outpatient should move to the hands of the physicians.
   - For CY2021, CMS is moving approximately 300 musculoskeletal-related services from the IPO list. These services will have an "indefinite" exemption from certain medical review activities. These include –
     - Exemption from site-of-service claim denials
     - Exemption from BFCC-QIO referrals to RACs for non-compliance with the two-midnight rule
     - Exemption from RAC reviews for patient status
   - These services will still be subject to billing in compliance with two-midnight rule and to review for education purposes. In addition, CMS has stated that the indefinite exemption from review ends when the service is predominantly provided on an outpatient basis.
   - Along with working to eliminate the IOL, CMS is moving an additional 278 procedures to the Ambulatory Surgical Center Covered Procedures List (ASC CPL) in CY2021, including total hip arthroplasty.

4. The final rule increases the services requiring prior authorization to include cervical fusion with disc removal and implanted spinal neurostimulators, effective with dates of service on or after July 2021.

5. CMS has changed the level of supervision for non-surgical extended duration therapeutic services, such as infusion services. The minimum default level of supervision for these services is general for the entire service. Previously, these services required direct supervision at the initiation of the service.



The final rule is available (display version) at beta.regulations.gov.

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