CY 2015 Medicare Outpatient Prospective Payment System (OPPS) Final Rule

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CY 2015 OPPS Final Rule with Comment Period

- Published in *Federal Register* on November 10, 2014, at page 66770

- Available at: http://www.gpo.gov/fdsys/pkg/FR-2014-11-10/pdf/2014-26146.pdf

- 487 HCPCS codes subject to comment (deadline, Dec. 30, 2014)

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Topics for Today's Teleconference

- Conversion Factor Update
- Collecting Data Re: Off-campus Provider-based Facilities
- New Packaging Policy
- Comprehensive APCs
- New and Revised CPT Codes – Interim HCPCS G-Codes
- Revised Physician Certification Requirements
- Inpatient-only List
- Outpatient Outlier
- Cost Threshold for Skin Substitutes
- Pass-through Payments for Devices
- No Cost/Full Credit and Partial Credit Devices
- Pass-through Payments for Drugs & Biologicals
- Separately Payable Drugs/Biologicals
- Cancer Hospital Payments
- Payment for Partial Hospitalization (PHP) Services
- Overpayments Associated with MA and Part D Data
- OQR/ASC Quality Programs Update

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Topics for Today's Teleconference

Topic	FR Pages (Nov 10, 2014)
Conversion Factor Update	66824 - 66826
Collecting Data Re: Off-campus Provider-based Facilities	66910 - 66914
New Packaging Policy	66819 - 66823
Creation of New "Comprehensive APCs"	66798 - 66816
Wage Index Update	66826 - 66828
Outpatient Outlier	66832 - 66834
Revised Physician Certification Requirements	66997 - 66999

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Topics for Today's Teleconference

Topic	FR Pages (Nov. 10, 2014)
Inpatient-only List	66909 - 66910
Pass-through Payments for Devices	66870 - 66871
No Cost/Full Credit and Partial Credit Devices	66872 - 66873
Pass-through Payments for Drugs & Biologicals	66874 - 66880
Separately Payable Drugs/Biologicals Paid at ASP +6%	66890 - 66891
Cancer Hospital Payments	66831 - 66832
Payment for Partial Hospitalization (PHP) Services	66900 - 66909
Overpayments Associated with MA and Part D Data	66999 - 67011
OQR ASC Quality Programs Update	66940 - 66966 66966 - 66987

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Conversion Factor Update

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CY 2015 OPPS Conversion Factor Update

- Use IPPS market basket increase = 2.9 percent
  - Less 2 percent if hospital doesn't submit quality data
- Less productivity adjustment = 0.5 percent
- Less ACA reduction = 0.2 percent
- Aggregate OPPS "update" = 2.2 percent

Off-Campus Provider-Based Facilities – Data Collection

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Data Collection: Off-Campus Provider-Based Facilities

- Reference to MedPAC concerns about higher payments to hospital-based facilities than freestanding clinics
- Last year, asked for preference on how to collect info (claims-based approach v. cost report), and got no consensus
- Finalized new policy on data collection – not payment change

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Data Collection: Off-Campus Provider-Based Facilities

- FINAL RULE: optional for January 1, 2015, REQUIRED for January 1, 2016
  - Hospitals:
    - Use HCPCS modifier "PO" with every code for outpatient hospital services furnished in off-campus provider-based department, reported on UB-04 (CMS Form 1450)
  - Physicians:
    - Use 2 new POS codes on form CMS-1500 to identify on- or off-campus service
      - Will delete POS 22 (outpatient hospital depts)
      - New codes not available yet

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Data Collection: Off-Campus Provider-Based Facilities

- Definition of off-campus?
  - Does not include remote location of a hospital, a satellite facility, or emergency departments
  - Does include provider-based departments located more >250 yards from main campus of hospital
- Services furnished on- and off-campus on same day?
  - "The location where the service is actually furnished would dictate the use of the modifier, regardless of where the order for services initiated."
  - Use modifier if hospital "expends resources" to furnish the service in an off-campus setting
- CMS will issue subregulatory guidance

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Packaging

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Finalized New Packaging Policies

- CMS expanded packaging to 2 more categories of items and services:
  1. Ancillary Services (but only for APCs with proposed geometric mean cost ≤ $100)
  2. Prosthetic Supplies
- Why? To continue to make OPPS more like a prospective payment and less like a fee schedule

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Packaging Ancillary Services

- Finalized policy to package when:
  - Performed with another service (still separately paid when performed alone)
  - Ancillary service APC has proposed geometric mean cost ≤ $100
    - So, does not include APC 0634 (clinic visit), because geo mean cost = $119.87
- Acknowledged policy may disproportionately affect teaching hospitals but this did not persuade CMS to change policy

Note: once packaged, always packaged

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Packaging Ancillary Services, cont. (no changes from proposed rule)

- Exclusions:
  - Preventive services (see Table 11)
  - Certain psychiatry and counseling-related services
  - Certain low cost drug administration services
- Status indicators?
  - Deleting SI “X”
  - Most will now go to SI “Q1” (STV-Packaged Codes)
  - Remaining, not conditionally packaged, go to SI “S” (Procedure or Service, Not Discounted When Multiple)

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Packaging Prosthetic Supplies

- Prosthetic supplies currently paid under DMEPOS Fee Schedule, even when provided in HOPD
- Finalized policy to package beginning CY 2015, because “all of the components are typically necessary for the performance of the system and the hospital typically purchases the system as a single unit”
- Replacement supplies provided later, still paid under DMEPOS Fee Schedule

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Comprehensive APCs

Comprehensive APCs (C-APCs)

- Comprehensive APC = a primary service and all adjunctive services provided to support the delivery of the primary service
  - Paid with one single prospective payment anytime a primary procedure (SI = J1) appears on a claim
  - Other services conditionally packaged
- Finalized last year but implementation deferred
- For C-APCs, package ALL add-on-codes (SI = "N")

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C-APCs: 2015 Final Rule Policy

Finalized C-APC policy, effective CY 2015, with some changes

- Establishes 25 C-APCs (vs 28 in proposed rule)
- Removed 3 from list, because frequently performed as secondary procedures to other more costly, non-C-APC procedures:
  - 0427 (Level II Tube or Catheter Changes or Repositioning)
  - 0622 (Level II Vascular Access Procedures)
  - 0652 (Insertion of Intraperitoneal and Pleural Catheters)
- No changes to account for services provided within 1-2 days of the primary service (hospital should file separate claims for unrelated services)

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C-APCs: Complexity Adjustment Changes

CY 2014	CY 2015
Comprehensive geometric mean cost >2x comprehensive geometric mean cost of single major claims reporting only primary service, AND	Violation of the 2x rule (i.e. comprehensive geometric mean cost of complex code combination exceeds comprehensive geometric mean cost of lowest significant HCPCS code assigned to the C-APC)
>100 claims/year reporting code combination, AND	≥ 25 claims reporting the code combination
Code combo = >5% of volume of all claims reporting primary service, AND	
No violation of "2 times" rule within receiving C-APC	

Notes: (1) If complexity adjustment, reassigned to higher level C-APC within same clinical family; if already in highest level C-APC within family, no complexity adjustment (applies to 7 code pairs) (2) Statute does not permit adjustments based on diagnosis.

C-APCs: Exclusions for CY 2015

Table 6 contains exclusions – NOT bundled into C-APC:

- Ambulance services
- Bracytherapy
- Diagnostic & mammography screenings
- PT, speech-language pathology, occupational therapy services
- Pass-through drugs, biologicals, and devices
- Preventive services (e.g., annual wellness visits)
- Self-administered drugs
- SI “F” (certain CRNA services, Hep B vaccines, corneal tissue acquisition)
- SI “L” (influenza and pneumococcal pneumonia vaccines)
- Certain Part B inpatient services

New and Revised CPT Codes: Interim HCPCS G-Codes

New and Revised CPT Codes: Use of New HCPCS G-Codes

- CMS modified current process for accepting comments on new and revised CPT codes (also in PFS proposed rule), effective 2016
- Why? Concern re: lack of opportunity for public comment prior to Jan. 1 implementation date
- Current process:
  - AMA publishes CPT codes in the fall, effective January 1
  - CMS assigns interim APCs and SIs, and opens public comment during OPPS final rule
  - CMS pays under interim designations for 1 year
  - Comments addressed in following year's final rule

New and Revised CPT Codes, cont.

Revised Process:

- New/revised CPT codes received too late for inclusion in proposed rule:
  - Delay adoption of new codes
  - Create and use HCPCS G-codes that mirror the predecessor codes, and keep current APC and SI for one year
    - CMS finalized over objections re: burden of temporary G-codes (said CMS will "make every effort" to avoid using the G-codes)
    - G-codes will be assigned comment indicator "NI" – new and open for comment for 60 days
  - Include proposed assignment in following year's proposed rule

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New and Revised CPT Codes, cont.

Proposed Revised Process, cont.:

- "Wholly New Services":
  - Will "make every effort to work the AMA CPT Editorial Panel" to get the codes in time for the proposed rule
  - If not in time, will establish interim APC and SI for 1 year (i.e. follow current process)

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Physician Certification

Physician Certification

- **Physician order** → required for all inpatient admissions
  - Needed for the beneficiary to be considered an inpatient
  - Triggers the requirement for payment under Part A
  - CMS removes the physician order requirement as an element of certification. Instead, it will be required under its general rulemaking authority (Sec. 1871 of the SSA).
- CMS will **only** require **physician certification** for long-stay cases (20 days or longer) and other outlier cases

Physician Certification

- Physician certification required for Part A payment for inpatient hospital services for cases that are 20 days or more or are outlier cases
- Physician must certify or recertify no later than 20 days into the hospital stay:
  1. The reasons for either:
     i. continued hospitalization of the patient for medical treatment or medically required diagnostic study; or
     ii. special or unusual services for cost outlier cases
  2. The estimated time the patient will need to remain in the hospital
  3. The plans for post-hospital care, if appropriate

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Outpatient Outlier Payments

Outpatient Outlier Payments

- Final outlier threshold: $2,775 (compared to $3,100 in the proposed rule and $2,900 in 2014)
- Final rule estimates:
  - Actual outlier payments in 2013 = 1.4% of total OPPS payments
  - Actual outlier payments in 2014 will = 0.8% of total payments
  - Compared to the 1.0 % set aside in both years

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Inpatient-Only List

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Inpatient Only List

- CMS is removing CPT code 63043 and 63044 from the 2015 inpatient list
  - Because they are add-on codes, both codes are being assigned status indicator “N” for CY 2015
- CMS is adding CPT code 22222 (Osteotomy of the spine, including discectomy, anterior approach, single vertebral segment; thoracic) to the 2015 inpatient list
- Complete list of codes to be paid only in the inpatient setting is available in Addendum E on CMS’ website

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High/Low Cost Threshold for Skin Substitutes

Proposed High/Low Cost Threshold for Skin Substitutes

CY 2014 OPPS final rule:

- CMS unconditionally packaged skin substitute products into their associated surgical procedures
- CMS established a methodology to divide skin substitutes into a high cost group and a low cost group for packaging purposes
  - In high cost group: Skin substitutes with a July 2013 ASP + 6% amount above $32 per cm^2
  - In low cost group: Skin substitutes with a July 2013 ASP + 6% amount at/below $32 per cm^2

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Proposed High/Low Cost Threshold for Skin Substitutes

For CY 2015, CMS finalizes: A revised methodology to establish the high cost/low cost threshold

- Would be based on the weighted average mean unit cost (MUC) for all skin substitute products from claims data
- Final MUC threshold would be 25 per cm^2 (compared to the proposed $27 threshold)
  - MUC above $25 per cm^2 → in high cost group
  - MUC at/below $25 per cm^2 → in low cost group
- If no claims data to calculate a MUC, CMS will use ASP + 6% payment rate
  - If that's not available, WAC + 6% or 95% of AWP

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Reasons for Revised Methodology

- CMS believes it will provide more stable high/low cost categories
  - Addresses concern that as new high priced skin substitutes gain market share, the weighted average ASP high/low cost threshold could escalate rapidly, resulting in shift of many skin substitutes from high to low cost category
- Because revised threshold is based on costs from outpatient claims data rather than manufacturer reported sales prices (including inpatient and outpatient sales), data will not include the larger product sizes and their lower per cm^2, used mainly for inpatient burn cases.

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Pass-Through Evaluation Process for Skin Substitutes

Effective 2015, CMS will:

- Evaluate applications for pass-through payment for skin substitutes using the medical device pass-through process and payment methodology.
- The last skin substitute pass-through applications evaluated using the drug and biological pass-through evaluation process will be those with an application deadline of Sept. 1, 2014, and an earliest effective date of Jan. 1, 2015.
- CMS also finalized changing the Dec. 1, 2014 pass-through application deadline for both drugs and biologicals and devices to Jan. 15, 2015.

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Pass-Through Payments for Devices

Pass-Through Payments for Devices

- CMS finalizes **expiration** for one device category eligible for pass-through payment in 2015: HCPCS code C1841 (Retinal prosthesis, includes all internal and external components)
  - **Final expiration date for HCPCS code C1841: Dec. 31, 2015**
  - After Dec. 31, 2015, CMS will package the cost of HCPCs code C1841 into the costs related to procedures with which it is reported in claims data (consistent with established policy).

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No Cost/Full Credit and Partial Credit Devices

No Cost/Full Credit and Partial Credit Devices

- Current policy: CMS reduces the payment for selected device-dependent APCs by the estimated amount of the APC payment attributable to device costs if the hospital receives a device at no cost or with a full/partial credit.
- For CY 2015: CMS will **continue** the policy of reducing OPPS payment by the full or partial credit a provider receives for a replaced device for specified device-dependent APCs.
- Hospitals will be required to report the amount of the credit in the amount portion for value code "FD" when the hospital receives a credit for a replaced device 50% or > than the device's cost.

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Pass-Through Payments for Drugs and Biologicals

Pass-Through Payments for Drugs and Biologicals

- Final 2015 OPPS Drug Packaging Threshold: $95
- CMS will pay for drugs and biologicals with pass through status at ASP + 6% for CY 2015
- CMS will continue pass-through status for 26 products and granted pass-through status for 9 drugs effective Jan. 1, 2015 (Table 29 of the final rule)
- CMS terminated pass-through payment status for 9 drugs and biologicals effective Jan. 1, 2015 (Table 28 of the final rule)

Payment Rate for Separately Payable Drugs and Biologicals

Payment Rate for Separately Payable Drugs and Biologicals

- **CY 2015 packaging threshold = $95** (compared to proposed packaging threshold of $90)
- **If a drug's average cost per day exceeds $95, it is separately payable, if not, it is packaged.**
  - To calculate the per day cost, CMS uses an estimated payment rate of ASP + 6 %
  - ASP-based payment rates for both the OPPS and physician office settings would continue to be updated quarterly using quarterly reported ASP data with a two-quarter lag.
  - Only HCPCS codes identified as separately payable in the final rule would be subject to quarterly updates.

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Payments to Certain Cancer Hospitals

Payments to Certain Cancer Hospitals

- The ACA requires an adjustment for 11 cancer hospitals with outpatient costs higher than those of other hospitals
- **Final adjustment for cancer hospitals**: difference between cancer hospital's payment to cost ratio (PCR) and weighted average PCR of other hospitals
  - Continues last year's policy of increasing each cancer hospital's PCR to equal PCR of other hospitals
  - For CY 2015, CMS calculates a target PCR of 0.89 (this year's estimated PCR of other hospitals)

Payments to Certain Cancer Hospitals

- Estimated hospital-specific payment adjustment for the 11 cancer hospitals show increases in OPPS payments range from 15.5%-60.1%
- The 2015 budget neutrality adjustment to the OPPS conversion factor is 1.0000 for the cancer hospital adjustment
  - Reflects CMS' projection that aggregate cancer hospital adjustments will be largely unchanged in 2015 compared to 2014

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Payment for PHP Services

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Payment for PHP Services

- Payment rates for the 4 partial hospitalization (PHP) APCs will be calculated using geometric mean per diem costs.
- Final 2015 per diem costs:
  - **Hospital-based PHPs:**
    - Level I: Decreased by approx. 2.6% as compared to 2014 costs
    - Level II: Decreased by approx. 5.3% as compared to 2014 costs
  - **CMHC PHPs:**
    - Level I: Increased by approx. 0.76% as compared to 2014 costs
    - Level II: Increased by approx. 5.7% as compared to 2014 costs
- While final costs for CMHCs increased compared to 2014 costs, CMHC geometric mean per diem costs continue to be substantially lower for CMHCs than for hospitals.

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2015 Geometric Mean Per Diem Costs & Payment Rates for PHP Services

Category	APC	Proposed Costs	Final Costs	Payment Rates
CMHC Level I	0172	$97.43	$100.15	$96.51
CMHC Level II	0173	$114.93	$118.54	$114.23
Hospital-Based Level I	0175	$177.32	$185.87	$179.11
Hospital-Based Level II	0176	$190.21	$203.01	$195.62

Overpayments Associated with MA and Part D Data

Overpayments Associated with MA and Part D Data

- CMS finalizes a formal process to recoup overpayments resulting from submission of erroneous payment data by a MA organization (MAO) or Part D sponsor. Effective January 1, 2015.
  - Applies when MAO or Part D sponsor fails to correct data after notice by CMS
  - Erroneous payment data = payment data that should not have been submitted either b/c the data submitted are inaccurate or because the data are inconsistent with Medicare Part D requirements
  - Does not replace established recovery and appeals processes

Overpayments Associated with MA and Part D Data

- If CMS ID's a payment data error resulting in overpayment, CMS will issue a corrections notice to the MAO or Part D sponsor ID'ing the error, the timeframe to correct it, and may include additional information relevant to the offset.
- Same 6-year look back period as applies for correction of plan-identified overpayments.
- Failure to correct erroneous payment data ID'ed by CMS will result in a payment offset if the payment error affects payments for any of the 6 most recently completed payment years and the payment error for a particular payment year is ID'ed after the applicable reconciliation date for that payment year.

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Quality Measures/Programs for CYs 2017/2018

Quality Measures/Programs for CYs 2017/2018

- **Outpatient Quality Reporting (OQR) Program:**
  - One new measure finalized starting CY 2018 (OP-32)
  - Two measures finalized for removal due to being topped out starting CY 2017 (OP-6 & OP-7)
  - One measure finalized for voluntary reporting starting 2017 (OP-31)
- **Ambulatory Surgical Center Quality Reporting (ASCQR) Program:**
  - One measure finalized for inclusion starting CY 2018 (ASC-12)
  - One measure finalized for voluntary reporting starting CY 2017 (ASC-11)

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Hospital Outpatient Quality Reporting (OQR) Program

New Measure Finalized for CY 2018 (OP-32)

- OP-32: Facility Seven Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
- Claims-based measure
- Measure is not NQF endorsed and was conditionally supported by the Measure Applications Partnership (MAP)
- CMS will perform a dry run of the measure in 2015. Hospitals will have an opportunity to review confidential performance results. Results will not be publicly reported

Two Measures Finalized for Removal in CY 2017 (Topped Out)

- OP-6: Timing of Antibiotic
- OP-7: Prophylactic Antibiotic Selection for Surgical Patients

Voluntary Measure Finalized for CY 2017 (OP-31)

- OP-31: Cataracts – Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery will be a voluntary measure starting CY 2017.
- Measure was previously finalized starting CY 2016. Measure is now excluded from CY 2016 data collection
  - CMS notes that the collection and reporting of this data is operationally difficult for hospitals; measure would also utilize inconsistent surveys to assess visual function

Data Submission Timelines and Procedures for CY 2017

Chart Abstracted Measures	• Data must be submitted 4 months following the end of the calendar quarter • 12 mandatory measures for CY 2017
Claims Based Measures	• Data calculations will be based on a 12-month period from July 1, 2014 through June 30, 2015 • 6 mandatory measures for CY 2017 (public reporting of OP-15 continues to be deferred) • 1 additional measure starting CY 2018
Web-based Measures	• Data must be submitted between July 1, 2016 and November 1, 2016 with respect to performance on measures for CY 2015 • 4 mandatory measures for CY 2017
NHSN Measure	• Data must be reported via the CDC NHSN by May 15, 2016 for the period October 1, 2015 through March 31, 2016 • 1 mandatory measure for CY 2017 (healthcare worker vaccination measure) → combined inpatient and outpatient measure

Requirements for OQR mandatory measures only

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Ambulatory Surgical Center Quality Reporting (ASCQR) Program

Process to Immediately Remove Measures

- CMS finalized a process to immediately remove measures from the ASCQR Program if continued data collection may result in harm to patients.
- This is the same process adopted for the IQR and OQR programs
- If such situations occur, CMS would promptly retire the measure, immediately alert stakeholders, and confirm the measure's retirement in the next rulemaking cycle

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New ASC Measure Finalized for CY 2018 (ASC-12)

- ASC-12: Facility Seven Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
- Measure is not NQF endorsed and was conditionally supported by the MAP
- CMS will perform a dry run of the measure in 2015. Hospitals will have an opportunity to review confidential performance results. Results will not be publicly reported

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Voluntary Measure Finalized for CY 2017 (ASC-11)

- ASC-11: Cataracts – Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery will be excluded from CY 2016 data collection
- Finalized as a voluntary measure starting CY 2017
  - CMS notes that the collection and reporting of this data is operationally difficult for ambulatory surgical centers. Measure would also utilize inconsistent surveys to assess visual function

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New AAMC Measures Spreadsheet

Overview of Hospital Performance and Reporting Measures

This AAMC spreadsheet consists of the inpatient measures reported on Hospital Compare and used in the Inpatient quality Reporting (IQR) Program, Value Based Purchasing (VBP) Program, Hospital Acquired Conditions (HAC) Reduction Program, and Hospital Readmissions Reduction Rrogram (HRRP). The last two tabs on this spreadsheet contains measures in the Hospital Outpatient Quality Reporting (OQR) Program, along with those required by the Joint Commission. All measures are finalized, unless otherwise noted. **This tab consists of all the inpatient measures, and their inclusion in the IQR, VBP, HRRP, and HAC Programs.** Free feel to use this information in a way that is relevant to your institution. In the spreadsheet, CY refers to the calendar year and FY refers to the Federal fiscal year, which runs from October 1 through September 30. "X" represents measures that hospitals have the option to electronically report. "V" indicates a voluntary EHR measure (Not required for IQR). For additional resouces on these measures, please go to

Measure	Payment Year IQR Program			Payment Year VBP Program					Payment Year HAC Reduction Program			Payment Year Readmissions Reduction Program		
	FY 2015	FY 2016	FY 2017	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2015	FY 2016	FY 2017	FY 2015	FY 2016	FY 2017
Acute Myocardial Infarction (AMI) Measures (Chart Abstraction)														
AMI-1: Aspirin at Arrival	Suspended													
AMI-2: Aspirin at Discharge	X	Removed	V											
AMI-3: ACEI or ARB for left ventricular systolic dysfunction-ami (previously suspended)	Suspended													
AMI-5: Beta-Blocker Prescribed at Discharge for AMI (previously suspended)	Suspended													
AMI-7a Fibrinolytic therapy received within 30 minutes of hospital arrival	X	X	X	X	X	X	X	X						
AMI-8a : Primary PCI received within 90 minutes of hospital arrival	X	X	V	X	Removed									
AMI 10: Statin at discharge	X	Removed	V											
Heart Failure (HF) Measure (Chart Abstraction)														
HF-1 Discharge Instructions	X	Removed		X	Removed									
HF-2 Evaluation of left ventricular systolic function	X	X	Removed											
HF-3 Angiotensin Converting Enzyme Inhibitor (ACE-I) or Angiotensin II Receptor Blocker (ARB) for Left Ventricular Systolic Dysfunction	X	Removed												
Stroke (STK) Measure Set (ChartAbstraction)														
STK-1 Venous thromboembolism (VTE) prophylaxis	X	X	X											
STK-2 Discharged on antithrombotic therapy	X	X	V											
STK-3 Anticoagulation therapy for atrial fibrillation/flutter	X	X	V											
STK-4 Thrombolytic therapy	X	X	X											
STK-5 Antithrombotic therapy by the end of hospital day two	X	X	V											
STK-6 Discharged on statin medication	X	X	X											
STK-8 Stroke education	X	X	X											
STK-10 Assessed for rehabilitation	X	X	V											
Abstraction)														
VTE-1 Venous thromboembolism prophylaxis	X	X	X											
VTE-2 Intensive care unit venous thromboembolism	X	X	X											
VTE-3 Venous thromboembolism patients with anticoagulation overlap therapy	X	X	X											
VTE-4 Patients receiving un-fractionated Heparin with doses/labs monitored by protocol	X	X	V											
VTE-5 VTE discharge instructions	X	X	X											
VTE-6 Incidence of potentially preventable VTE	X	X	X											

Available at www.aamc.org/hospitalpaymentandquality under "AAMC Quality Measures Spreadsheet"

QUESTIONS?