AAMC

Tomorrow's Doctors, Tomorrow's Cures

Learn

Serve

Lead

# CY 2013 Medicare Outpatient Prospective Payment System (OPPS) Final Rule

Lori Mihalich-Levin, J.D.
(lmlevin@aamc.org; 202-828-0599)

Jane Eilbacher
(jeilbacher@aamc.org; 202-828-0896)

Scott Wetzel
(swetzel@aamc.org; 202-828-0495)

December 5, 2012

Association of American Medical Colleges

# Outpatient PPS Final Rule

- Published in *Federal Register* on November 15, 2012, at page 68210

- Available at: http://www.gpo.gov/fdsys/pkg/FR-2012-11-15/pdf/2012-26902.pdf

# Topics for Today's Teleconference

- Conversion Factor Update
- Use of Geometric Mean to Set APC Relative Weights
- Payments to Certain Cancer Hospitals
- Payment Rate for Separately Payable Drugs/Biologicals
- Transitional Care Management
- Payment Adjustment for Certain Radioisotopes
- Inpatient Only Procedures
- Outpatient Status
- New Technology APCs
- Transitional Pass-Through Payments
- Hospital Outpatient Quality Reporting Program
- ASC Quality Reporting Program
- IRF Quality Reporting Program



AAMC

# CY 2013 OPPS Conversion Factor Update

- Use IPPS market basket increase = 2.6 percent
  - Less 2 percent if hospital doesn't submit quality data
- Less multi-factor productivity adjustment = 0.7 percent
- Less an additional 0.1 percent
- Aggregate OPPS "update" = 1.8%



Source: 77 *Fed. Reg*. 68283-68285

# Use of Geometric Mean to Set APC Relative Payment Weights

- Relative weight of APC:
  - Measures resource requirements for service
  - Based on median cost of services since start of OPPS
  - Proposal to use geometric mean instead of median

- CMS finalized change to geometric mean. Why?
  - More accurate capturing of variation in costs
  - Improved sensitivity of the “two times” rule
  - Promotes stability of payments by having weights more reflective of costs
  - Consistency with IPPS methodology



**Source: 77 *Fed. Reg.* 68259-68262**

# Use of Geometric Mean (cont.) – Effect on Teaching Hospitals

Effect of proposal to use geometric mean on payments?

- Budget neutral overall
- But differential impact depending on provider type
- CMS estimates -0.1% impact on major teaching hospitals
- AAMC analysis indicates larger impact on COTH members

| Hospital Category | % Change from 2013 Using Median |
|---|---|
| All | -0.13% |
| Major Teaching | -0.19% |
| Other Teaching | -0.16% |
| Non-Teaching | -0.08% |
| COTH | -0.20% |

# Payments to Certain Cancer Hospitals

- ACA requires adjustment for 11 cancer hospitals with outpatient costs higher than those of other hospitals
- Proposed adjustment for cancer hospitals = difference between cancer hospital's payment to cost ratio (PCR) and weighted average PCR of other hospitals
- Final Rule?
  - Continue last year's policy of increasing each cancer hospital's PCR to equal PCR of other hospitals (0.91)
- Adjustments made at cost report settlement



Source: 77 *Fed. Reg.* 68293-68294

# Payment Rate for Separately Payable Drugs and Biologicals

CY 2013 packaging threshold = $80 (up from $75 in 2012)

Final payment rate = Average sales price (ASP) + 6% (up from ASP + 4% in CY 2012)

- Abandons current methodology (involving overhead adjustment and complex calculation)
- Uses statutory default rate of ASP +6%



**Source: 77 *Fed Reg.* 68385-68389**

# Transitional Care Management

- See PFS for full details
- Proposal was for new HCPCS G-code (not separately payable) for care management when beneficiary transitions from hospital, SNF, or CMHC stay to physician care in the community
- Final Rule:
  - CMS assigned to 2 new CPT codes (and assigned those to 2 APCs) – open for comment
  - Includes face-to-face and non-face-to-face services
  - Starts date of discharge and lasts 29 days



**Source: 77 *Fed. Reg.* 68403-68404**

# Payment Adjustment for Certain Radioisotopes

- Re: technetium-99 (Tc-99m), used for diagnostic imaging, CMS finalized:
  - $10 per dose payment adjustment when produced in reactors that don't use highly enriched uranium (HEU)
    - Considered completely derived from non-HEU sources (and eligible for $10 payment) if dose contains no more than 5% HEU sourced Mo-99
  - Goal? Support Obama administration policy to eliminate domestic reliance on legacy reactors outside of US



**Source: 77 *Fed. Reg.* 68316-68323**

# Inpatient Only List

- Each year CMS reviews the current list of procedures on the inpatient list to identify any performed frequently in outpatient setting
- Five criteria determine removal from inpatient list
- For CY 2013, CMS proposed removing two procedures from the inpatient list:
  - CPT 22856 (total disc arthroplasty)

  (assign to APC 0208)
  - CPT 27447 (total knee arthroplasty)

  (assign to APC 0425)
    - After reviewing public comments, CMS has elected to keep CPT 27447 on the inpatient only list.



**Source: 77 *Fed Reg.* 68418-68424**

# Outpatient Status

- In the proposed rule, CMS sought comments on potential changes to the outpatient status policy, such as:
  - Clarify current instruction regarding circumstances where Medicare will pay for inpatient stay
  - Establish a point in time when encounter becomes an inpatient stay
  - More specific criteria regarding patient status
  - More specific clinical criteria for admission and payment



Source: 77 *Fed Reg.* 68428-68433

# Outpatient Status (cont.)

- CMS received approximately 350 public comments on this issue. CMS does not make any policy changes in the final rule.
- CMS group comments into the following categories:
  1. Part A to Part B Rebilling
  2. Clarifying Current Admission Instructions or Establishing Specified Clinical Criteria
  3. Hospital Utilization Review
  4. Prior Authorization
  5. Time-Based Criteria for Inpatient Admission
  6. Payment Alignment
  7. Other Topics (incl. Rules for External Review of Inpatient Claims, Improving Beneficiary Protections, and Revising the Qualifying Criteria for SNF Coverage)



**Source: 77 *Fed Reg.* 68428-68433**

# New Technology APCs

- CMS proposed to move HCPCS codes G0417-G0419 from New Technology APCs to clinical APC 0661 (Level V Pathology), which has proposed cost of $160 for CY 2013

TABLE 18—PROPOSED REASSIGNMENT OF PROCEDURES ASSIGNED TO NEW TECHNOLOGY APCS FOR CY 2013

| CY 2012 HCPCS Code | CY 2012 Short Descriptor | CY 2012 SI | CY 2012 APC | Proposed CY 2013 SI | Proposed CY 2013 APC |
|---|---|---|---|---|---|
| G0417 | Sat biopsy prostate 21–40 | S | 1505 | X | 0661 |
| G0418 | Sat biopsy prostate 41–60 | S | 1506 | X | 0661 |
| G0419 | Sat biopsy prostate: >60 | S | 1508 | X | 0661 |

- CMS did not receive any public comments on this issue and is finalizing the proposal.



Source: 77 *Fed Reg.* 68313-68315

# Pass-Through Payments for Devices

- CMS finalized that device pass-through categories C1830, C1840, and C1886 will continue to receive pass-through payments through CY 2013
  - Jan. 1, 2014, these categories will no longer be eligible for pass-through payment
- Finalized that pass-through payments for C1749 devices expire Dec. 31, 2012
- CMS finalized a clarification to its new device policy to include that a new device is not similar to predicate devices that once belonged in any existing or previously in effect pass-through device categories



**Source: 77 *Fed Reg.* 68352-68356**

# Pass-Through Payments for Drugs and Biologicals

- Finalized to be paid at ASP+6 percent for CY 2013 (equivalent to physician's offices and same as CY 2012)



Source: 77 *Fed Reg.* 68397-68399

# Hospital Outpatient Quality Reporting Program (HOP QDRP)

# Measures for CYs 2015 & 2016

- No new quality measures were added to the OQR program
- Hospitals will continue to report measures previously finalized in CY 2012, with a few exceptions.
- Similar to the IQR program, CMS will automatically include new measures for future payment years, unless otherwise noted



**Source: 77 *Fed Reg.* 68467-68473**

# MAP Recommendations

- The Measure Applications Partnership (MAP) recommended seven measures be removed from the OQR program
- While the MAP supported the directions of these measures, it is believed that they need further development before inclusion into the OQR program
- CMS did not recommend that these measures be removed in the final rule

| NQF Measure # and Status | Measure Name/Title |
|---|---|
| 0498 Endorsed (NQF endorsement to be removed) | OP–20: Door to Diagnostic Evaluation by a Qualified Medical Professional |
| 0499 Endorsed (NQF endorsement to be removed) | OP–22: ED–Patient Left Without Being Seen |
| Not NQF Endorsed | OP-9: Mammography Follow-Up Rates |
| Not NQF Endorsed | OP-10: Abdomen CT-Use of Contrast Material: For Diagnosis Of Calculi In The Kidneys, Ureter, And/Or Urinary Tract—Excluding Calculi Of The Kidneys, Ureter, And/Or Urinary Tract |
| Not NQF Endorsed | OP-14: Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT) |
| Not NQF Endorsed | OP-15: Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache |
| Not NQF Endorsed | OP-25: Safe Surgery Checklist |

# Data Collection Announcements

**Data collection and reporting delays for four previously finalized measures:**

| Measure Name | Measure Update |
|---|---|
| OP-19: Transition Record with Specified Elements | Data collection has been suspended until further notice. Hospitals must still submit data for this field, although a generic answer may be imputed into the system |
| OP-24: Cardiac Rehabilitation | Data collection will be postponed until Jan. 1, 2014 (instead of Jan. 2013). This measure will now be used for CY 2015 Payment Determination |
| OP-15: Use of Brain Computed Tomography | Data will not be reported on Hospital Compare in 2012 and will not be required for CY 2014 Payment Determination. Public reporting will occur in July 2013 at the earliest |
| OP-16: Troponin results for Emergency Department AMI patients" | Measure removed from OQR program. Hospitals must still submit a meaningless value until Jan 1, 2013. |



Source: 77 *Fed Reg.* 68473-68476

# Claims Based Measures

- For CY 2015 Payment Determination, CMS finalized its proposal to use Medicare FFS claims for services between July 1, 2012 through June 30, 2013
- CMS currently uses a 12-month calendar year period
- This change will align the data periods for outpatient and inpatient claims based measures on Hospital Compare



**Source: 77 *Fed Reg.* 68482-68483**

# Submission Deadlines Extended for Structural Measures

- CMS will extend the submission deadline for structural measures an additional 2.5 months for CY 2014 and CY 2015
- Hospitals will submit data between July 1, 2013 and Nov 1, 2013 (Previous deadline was August 15, 2013) with respect to the time period of Jan 1 to Dec 31, 2012
- This change affects OP-22: ED-Patient Left Without Being Seen
  - Although this is a chart abstracted measure, data is collected via a web tool and therefore it is treated as a structural measure



**Source: 77 *Fed Reg.* 68483-68484**

# EHR Incentive Program Electronic Reporting Pilot

- CMS will continue to allow hospitals the option of submitting quality data through the Electronic Reporting Pilot (finalized in the CY 2012 OPPS rule) in order to satisfy Meaningful Use, Stage 2 requirements
- Hospitals will still be able to submit quality data via attestation for CY 2013



**Source: 77 *Fed Reg.* 68490-68492**

# Selection of Hospitals for Data Validation

- In the CY 2012 OPPS Final Rule, CMS reduced the number of hospitals randomly selected for data validation from 800 to 450
- This policy will continue in future years
- CMS will also continue a policy to select 50 additional hospitals, based on specific criteria, to ensure data accuracy. Targeting criteria for CY 2014 is based on:
  - A hospital's failure to meet the validation requirement for CY 2012 payment determination; or
  - If a hospital has an outlier value for a measure based on the data it submits



**Source: 77 *Fed Reg.* 68531**

# OQR Reconsideration Process Changes

- Previously, the CEO was required to sign off on any hospital pursuing a reconsideration request
- Starting in CY 2014 PD the hospital may instead designate a contact to sign the reconsideration form
- CMS also finalized that the Agency will:
  - Issue an email response acknowledging receipt of the reconsideration request
  - Provide a formal response to the hospital designee with the reconsideration process decision



**Source: 77 *Fed Reg.* 68531-68532**

# Ambulatory Surgical Centers Quality Reporting Program (ASCQR)

# ASC Measures

- CMS retained previously finalized measures, and will not adopt any new measures
- ASCs that fail to meet the reporting requirements of the ASCQR program will receive a 2.0 percentage point reduction in its annual update



Source: 77 *Fed Reg. 68532-68535*

# Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)

# Expansion of Two IRF Measures

- CMS will include NQF's changes to the NHSN CAUTI Outcome Measure (NQF #0138) for FY 2014 Payment Determination, and formally include the new measure for FY 2015 Payment Determination
  - Measure will be expanded beyond the ICU to include IRFs
  - Measure uses different data calculation method- standardized infection ration (SIR). IRFs will continue to submit CAUTI data to CDC via NHSN



Source: *77 Fed Reg. 68533-68534*

# Expansion of Two IRF Measures, Cont

- In the FY 2012 Final Rule, CMS adopted the measure "Percent of Residents with Pressure Ulcers that are new or worsened (NQF #0678)" for the IRF setting
  - CMS requested that NQF review the measure with an expanded care setting to include IRFs. The NQF review of the request is still in progress
  - CMS will adopt a non-risk-adjusted version (numerator and denominator data only) of the measure, collect this data using the IRF-PAI, and not require public reporting this data until certain requirements are met.



**Source: 77 *Fed Reg.* 68533**

# Questions?

## To Ask a Question:

- All lines are currently muted.
- If you'd like to ask a question, click the 

button on the Participants' panel.

- AAMC staff will announce when your line is un-muted, and prompt you to ask your question.
- Your line will be re-muted when you are done asking your question (and any relevant follow-ups).



AAMC