The 2014 Outpatient Prospective Payment System (OPPS) Update

**Background**

Section 4523 of the Balanced Budget Act of 1997 (BBA), as amended by sections 201 & 202 of the Balanced Budget Refinement Act of 1999 (BBRA), provides authority for CMS to implement an outpatient prospective payment system (OPPS) under Medicare for:

(1) hospital outpatient services (HOPD),

(2) certain Part B services furnished to hospital inpatients who have no Part A coverage (Part B only), and

(3) partial hospitalization services furnished by community mental health centers (CMHC).

Services paid under the OPPS are classified into groups called Ambulatory Payment Classifications or APCs. APCs are composed of clinically similar services defined by CPT/HCPCS codes. A payment rate is established for each CPT/HCPCS code within an APC based on the geometric mean cost calculated from hospital claims and applied cost-to-charge ratios (CCRs) from hospital cost reports. Geometric mean cost for each CPT/HCPCS within each APC group is ranked from highest to lowest and the mean is selected. Median cost was the basis of calculating costs from the inception of APCs in 2000 through 2012. Beginning 2013, CMS changed the basis to geometric mean.

Services defined by CPT/HCPCS code in each APC are intended to be similar both clinically and in resource utilization. Depending on the services provided, hospitals
may be paid more than one APC for an encounter or visit. Hospitals are required to bill line item dates of service for outpatient services and the duration of a single encounter may include more than one calendar date of service (i.e., two or three contiguous calendar dates).

Section 4523 of the BBA changed the way beneficiary co-payment is determined for the services included under OPPS. At the outset of OPPS in 2000, a co-payment amount was initially calculated for each APC based on 20 percent of the national median charge for services in each APC. Subsequent to 2000, market basket updates to payment rates are applied only to the program payment portion of the APC until the co-payment proportion is no more than 20 percent of the total APC payment amount. New APCs are created at the 20 percent co-payment level. In addition, Section 204 of the BBRA provides that no single APC co-payment amount can be greater than the hospital inpatient deductible in a given year. Because there can be multiple APCs for a given outpatient claim, a beneficiary may owe significantly more in co-payment for a one or two day outpatient encounter than for a longer and more acute inpatient encounter. As of 2013, more than 85% of APCs have co-payment amounts of 20 percent. The aggregate beneficiary co-payments in 2014 is 21.7%.

Both the total APC payment and the portion paid as co-payment amounts are adjusted to reflect geographic wage variations using the inpatient prospective payment system (IPPS) hospital wage index. The portion of the APC payment that is attributable to labor is 60 percent.
The 2014 Outpatient Prospective Payment System (OPPS) Update

CMS's first final rule for OPPS was published in the Federal Register on April 7, 2000 (65 FR 18434). OPPS went into effect for services with dates on service on and after August 1, 2000.

Federal Register NPRM, Final Rules and Notices

- September 8, 1998 – HCFA-1005-P Proposed Rule [63 FR 47552]
- April 7, 2000 – HCFA-1005-FC Final Rule, Hospital outpatient services; prospective payment system [65 FR 18433]
- June 30, 2000 – Notice, Delay in effective date of OPPS [65 FR 40535]
- Nov. 13, 2000 – HCFA-1005-IFC Interim Final Rule with 2001 OPPS Updates [65 FR 67798]
- Jan. 9, 2001 – OPPS Correction Notice [66 FR 1599]
- May 4, 2001 – APR001A Update of CY 2001 OPPS Rates and Co-payment
- Nov. 2, 2001 – Final Rule with OPPS Conversion Factor [66 FR 55857]
- March 1, 2002 – CMS-1159-F4 Final Rule OPPS 2002 Updates [67 FR 9556]
The 2014 Outpatient Prospective Payment System (OPPS) Update

- Dec. 31, 2003 – CMS-1471-CN Correction Notice [68 FR 75442]
- Jan. 6, 2004 – CMS-1371-IFC Final Rule MMA OPPS Changes for Drugs [69 FR 820]
- Nov. 15, 2004 – CMS-1427-FC Final Rule 2005 OPPS Updates [69 FR 65681]
- Dec. 23, 2005 – CMS-1501-CN Correction Notice [70 FR 76176]
- Nov. 10, 2005 – CMS-1501-FC Final Rule 2006 OPPS Updates [70 FR 68516]
- Nov. 24, 2006 – CMS-1506-FC Final Rule 2007 OPPS Updates [71 FR 67960]
- Feb. 22, 2008 – CMS-1392-CN Correction Notice OPPS [73 FR 9860]
- Nov. 18, 2008 – CMS-1404-FC Final Rule for 2009 OPPS [73 FR 68502]
- Jan. 26, 2009 – CMS-1404-CN Correction Notice OPPS [74 FR 4343]
- July 20, 2009 – CMS-1414-P OPPS [74 FR 35232]
The 2014 Outpatient Prospective Payment System (OPPS) Update

- November 20, 2009 – CMS-1414-FC OPPS [74 FR 60310]
- August 3, 2010 – CMS-1504-P OPPS [75 FR 46170]
- November 24, 2010 – CMS-1504-FC [75 FR 71800]
- July 18, 2011 – CMS-1525-P [76 FR 42170]
- November 30, 2011 – CMS-1525-FC [76 FR 74122]
- Jan 4, 2012 – CMS-1525-CN [77 FR 217]
- July 30, 2012 - CMS-1589-P [77 FR 45061]
- November 15, 2012 – CMS-1589-FC [77 FR 68211]
- September 6, 2013 – CMS-1601-N [78 FR 54842]
- December 10, 2013 – CMS-1601-FC [78 FR 74826]

Other Information. See CMS Web Site at:

http://www.cms.gov/HospitalOutpatientPPS/

Other important OPPS resources, many of which can be found on the CMS web site, include:

- APCs and payment rates = Appendix A
- CPT/HCPCS and APC assignments or groupings and payment rates = Appendix B
- CPT/HCPCS and Status Indicator (SI) assignments = Appendix B
- Status Indicator Definitions = Addendum D1
- Packaged CPT codes = Addendum P
- Outpatient Code Editor (OCE) = http://www.cms.gov/OutpatientCodeEdit/
- OPPS Program Transmittals
- Advisory Panel on Hospital Outpatient Payment (HOP)
- Process and Information Required to Apply for Pass-Through Payment Status and New Technology Ambulatory Payment Classification (APC)
The 2014 Outpatient Prospective Payment System (OPPS) Update

- Device Code Edits
- Revenue Center to Cost Center Crosswalk

See the following web site for OPPS FAQ information:

https://questions.cms.hhs.gov/app/answers/list/kw/OPPS/sno/1/search/1/session/L3NpZC8teEV5UGFSaw%3D%3D

Coding Resource

Joint AHA/CMS site to submit HCPCS questions


Hospital Outpatient Services paid or encompassed by OPPS:

- All hospital outpatient services except those specifically excluded
- Hospital outpatient services rendered to SNF patients (not those considered part of SNF consolidated billing)
- Part B only for inpatients
- Implantable orthotics, prosthetics & biologics
- Take home surgical dressings
- Related clinical lab tests
- Administered drugs and self-administered drugs considered integral to OPPS services
- Identified with OPPS Status Indicators (SI) = G, H, K, N, P, Q1, Q2, Q3, R, S, T, U, V, X & J1

Hospital Outpatient Services excluded from OPPS:

- DME supplies (OPPS SI = Y)
The 2014 Outpatient Prospective Payment System (OPPS) Update

- Non-implantable orthotics & prosthetics (Note orthotics & prosthetics paid via DMEPOS fee schedule, but can be billed by hospital on UB92 along with OPPS services. OPPS SI = A)

- Ambulance, ESRD, Screening & diagnostic mammogram, rehabilitation services (paid by fee schedule, but billed by hospital on UB92 with OPPS services) OPPS SI = A

- Physician and non-physician practitioner professional services (paid by fee schedule, billed by hospital to carrier on 1500) Most CPT codes and some physician-only codes identified with OPPS SI = E & M

- Inpatient services. OPPS SI = C

- Non-covered services. OPPS SI = E

- Services not recognized under OPPS, but may be recognized by other institutional providers or there may be a better code. OPPS SI = B

- Services/CPT/HCPCS Codes deleted. OPPS SI = D

Coding and Billing of Claims & Payment Methodology

- HIPAA transaction set compliant HCPCS Level I (CPT4) and Level II (HCPCS) required with NUBC-defined revenue codes on outpatient claims.

- Packaged/Bundled services should not be reported with HCPCS such that separate APC payments would be made. (PM A-01-133). [Note: There is no good definition of packaged/integral/bundled services. 2013 change to language at 42 CFR 419.2 (b) Basis of Payment – changing the wording from “included costs” to “packaged costs” and adding the following sentence: “the following items and services, the payments for which are packaged into the payments for the related procedures and services.”]

- All HCPCS are mapped to an OPPS Status Indicator (SI). OPPS services may be mapped to an APC. HCPCS not mapped to an APC may be reportable, but do not receive separate payment under OPPS.
CMS defines packaged revenue codes and the revenue code-to-cost center crosswalk. CMS applies the hospital-specific CCR to the hospital’s charges based on a revenue code-to-cost center crosswalk containing a hierarchy of CCRs used to estimate costs from charges for each revenue code. The crosswalk is available for review and comment on the CMS Web site.

- SI used by OCE to calculate payment or apply claim edits.
- Each APC has a relative payment rate, but it has not been universally recognized to calculate an outpatient case mix unlike the DRG relative weights used for the inpatient case mix index (CMI)
- The wage portion for APCs remains 60 percent and the rate is wage adjusted using hospital inpatient PPS wage index. Due to various adjustments to the inpatient hospital wage index, CMS proposed for the first time in 2012 to deviate and not use the inpatient hospital wage index for OPPS payments. The decision was deferred after public comment and no change was proposed or made in 2013.
- From 2000-2003, transitional corridor payments were made to hospitals.
- Children’s hospitals are held harmless to 1996 payment levels
- Designated Cancer hospitals [11 hospitals] held harmless and beginning January 2012, receive a special adjustment to increase their “payment-to-cost ratio” (PCR) to the same level as CMS calculates for non-cancer OPPS hospitals.
- Rural hospitals with fewer than 100 beds are held harmless. MMA extended transitional corridor payments through Dec. 2005 and expanded to sole community hospitals & EACH in rural areas regardless of bed size. For 2006 - 2014, SCH & EACH rural hospitals receive a 7.1% payment adjustment.
- CMS reserves 1.0 percent of total OPPS payments for outliers with 0.2% reserved for CMHCs. Outlier payments are calculated by APC with packaged/bundled services prorated to each APC on the claim. Two thresholds apply – 1.75 times the APC plus a fixed amount equal to $2,900 for 2014. CMHCs subject to a 3.4 multiplier threshold. Cost report reconciliation of outlier payments possible if CCR changes significantly.
- Beneficiaries pay copayments no more than 40% of the APC payment rate and capped at the inpatient PPS deductible rate for each APC. 85% of APCs have co-payments defined at the 20% level.
- Co-payment reductions – hospitals may elect once per year and may reduce copayments for all HCPCS procedures in an APC no lower than the 20% of the payment rate. CMS has never reported on a hospital using this election.
The 2014 Outpatient Prospective Payment System (OPPS) Update

- Status indicator “T” HCPCS receive multiple procedure discount of 50% meaning one highest paid T procedure is paid at 100% and each other T procedure paid 50% of the applicable APC rate.

- Inpatient Only procedures or SI “C” – excluded and claim will reject except if patient dies in the ED prior to admission modifier –CA can be used and APC 0375 is paid for ancillary services only.

- Since 2008, OPPS has included composite APCs, where a set of HCPCS codes become the criteria for a single larger APC payment. Partial hospitalization services, electrophysiological services, prostate brachytherapy and Evaluation and Management (aka: observation services) are paid under composite APCs.

- Continued without significant change from 2009 are 5 new multiple imaging composite APCs based on 3 families of codes.

- New for 2012, CPT code 33325 has a Q3 status indicator and the outpatient code editor will assign CPT codes 33225 and 33249 when they appear on the same date of service to APC 0108. CMS refers to this assignment for APC 0108 as “compositing” yet it does not state that APC 0108 is a Composite APC.

- Upcoming in 2015, 29 Comprehensive APCs, considered a mini-DRG single payment for device-depending APCs.

Highlights of Significant 2014 Changes

- APC Financial Update – After ACA adjustments, market-basket update of 1.7 was applied to the OPPS conversion factor for those hospitals that participated in quality indicator reporting. This results in a conversion factor of $72.672 for hospitals that met the 2013 quality reporting requirements and $71.219 for hospitals that did not meet the 2013 quality reporting requirements.

- In 2013, CMS changed the calculation of costs from median to geometric mean more to better align with the calculation of costs used in IPPS. In 2014, with the addition of 3 new cost centers, the cost centers in the cost reports are aggregated into 18 for IPPS geometric mean cost calculations, whereas there is no such aggregation in OPPS.

*Geometric means better encompass the variation in costs that occur when

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The 2014 Outpatient Prospective Payment System (OPPS) Update

providing a service because, in addition to the individual cost values that are reflected by medians, geometric means reflect the magnitude of the cost measurements, and are thus more sensitive to changes in the data."

- In 2013, CMS applied the revenue code to cost center adjustments for the new “implantable devices charged to patients” cost center, and for 2014, Cath Lab, MRI and CT cost centers are added. Note that the new implantable devices cost center was used for 2014 IPPS rate setting. No changes to the list of packaged revenue codes.

- The percent outlier payment pool target remains 1.0 percent for 2014 and to achieve this level CMS will continue to make an outlier payment equal to 50 percent of the amount by which cost exceeds 1.75 times the APC payment amount plus a fixed-dollar threshold of $2,900. Outlier reconciliation thresholds are provided in section 10.7.2.1 of Chapter 4 of the Medicare Claims Processing Manual (Pub. 100-4), reevaluated annually, and modified if necessary.

- Partial Hospitalization Services – Continuing from 2012, two PHP APC per diem payment rates based on CMHC data and two PHP APC per diem payment rates based on outpatient hospital data. The ACA requires 40% of patients treated at a CMHC to be non-Medicare patients and explicitly excludes services furnished in a beneficiary’s home or an inpatient or residential setting from PHP services. APCs were re-configured based on the AMA psychiatric CPT changes for 2013.

- Drugs, Biologicals, Radiopharmaceuticals & Brachytherapy Sources – CMS conceded in 2013 and began paying ASP + 6 percent for separately payable drugs and biologicals in CY 2013 as authorized under section 1842(o) of the Act. The packaging threshold for drugs, biologicals and radiopharmaceuticals was updated from $90.

- Hospital Visits - No changes from CMS in the hospital E/M guidelines for ED visits, but for clinic visits, 20 HCPCS codes were collapsed to one G code for visits and one APC rate.
The 2014 Outpatient Prospective Payment System (OPPS) Update

- Despite the 2012 CPT changes to the definition of Critical Care codes 99291 and 99292 to explicitly remove reference to bundled codes like ECG interpretations for facilities, CMS did not change payment policy because they did not see a difference in hospital billing and cost of critical care services. CMS continues to allow separate billing, but no separate payment even though they now have the claims data to re-price the procedures separately.

Hospital Outpatient Quality Data Reporting & Measures

- In order for hospitals to receive the full APC payment rate update for 2014, data must have been reported on:
  - 7 HOP QDRP measures defined for 2009 (5 AMI and 2 periooperative measures) and CMS will calculate the same 4 imaging “efficiency” measures from claims data for each hospital; and
  - Four (4) new measures added in 2011: 1 structural health information technology measure & 3 claims-based imaging efficiency measures

- Plus eight new measures added in 2012 for a total of 23: 1 structural measure – tracking clinical results between visits using HER & 6 chart-abstracted measures related to timeliness, appropriate, and efficient care provided in the emergency department:
  - Median time from ED arrival to ED departure for discharged ED patients
  - Transition record w/ specified elements received by discharged patients
  - Door to diagnostic evaluation by a qualified medical professional
  - ED median time to pain management for long bone fracture
  - ED – Left without being seen
  - ED head CT scan results for acute ischemic stroke or hemorrhagic shock who received head CT scan interp w/in 45 minutes of arrival
Changes in Physician Supervision Requirements

- CMS continues to have challenges creating physician supervision rules for hospital outpatient departments that are viable across rural, critical access and other hospitals. CMS makes a distinction between Conditions of Participation requirements for supervision and those required for coverage and payment policy. As a result of the controversy, CMS will begin enforcing the supervision changes on Critical Access or small rural hospitals for 2014.

- For 2011, CMS changed the definition of supervision to remove any reference to physical location and it states that the physician must be **physically present**.
interruptible, and able to furnish assistance and direction throughout the performance of the procedure

- CMS proposed a list of 16 CPT services called “Non-surgical Extended Duration Services” whereby a physician needs to meet direct supervision at the initiation of the service and can transition to general supervision and this must be documented and is left up to the physician for each additional services. While CMS is obviously trying to be flexible, it is questionable whether this approach results in any real operational flexibility.

- For 2012, CMS finalized plans to expand the scope of the existing APC Advisory Panel [now called the Advisory Panel on Hospital Outpatient Payment] to review supervision levels by code and also added new seats to the committee to include rural and CAH representation. It is anticipated that this review process will result in a CPT list with supervision defined at various levels much like diagnostic service supervision levels in the MPFS. During 2012, the Panel reviewed services at both of its meetings and recommended a number of services be liberalized to the general level of supervision. http://www.cms.gov/Medicare/Medicare-Fee-for-Service-HospitalOutpatientPPS/index.html?redirect=/HospitalOutpatientPPS/01_overview.asp

- To date, value-based purchasing (VBP) remains focused on inpatient services with 70% process of care or quality measures and 30% experience of care measures. No real proposal has been offered to include outpatient hospital services in VBP initiatives.