CY13 OPPS Final Rule Fact Sheet

Introduction

The Centers for Medicare & Medicaid Services (CMS) released a final rule with comment period that updates payment rates for hospital outpatient services paid under the Medicare outpatient prospective payment system (OPPS) and establishes relative payment weights and amounts for services furnished in ambulatory surgical centers (ASCs) for the calendar year 2013 (CY13) ASC payment system. These final changes will be applicable to services furnished to Medicare beneficiaries beginning January 1, 2013. CMS also proposes to update the requirements for both the Hospital Outpatient Quality Reporting (OQR) Program and the ASC Quality Reporting (ASCQR) program. CMS also proposes revisions to the electronic reporting pilot for the Electronic Health Record (EHR) Incentive Program and the various regulations governing Quality Improvement Organizations (QIOs). The final rule with comment period is effective on January 1, 2013.

CY12 OPPS Final Updates Impact Table

The table below reflects the impact of the final rule on hospitals after all CY13 updates have been made. CMS provides a more comprehensive list in Table 57 of the final rule.

CY13 OPPS Update Impact Table

	All Changes (Percentage)
All Hospitals	1.9
Urban Hospitals	1.9
Rural Hospitals	2.2
Teaching Status	
Non-Teaching	2.1
Minor	1.7
Major	1.8

Under the final rule, CMS estimates that total payments, including beneficiary cost-sharing for CY13 to facilities paid under the OPPS, will be approximately **$48.1 billion**, an increase of approximately $4.6 billion compared to CY12 payments, or $600 million excluding estimated

changes in enrollment, utilization, and case-mix.

OPPS Payment Rate Updates

Section 1833(t)(3)(C)(ii) of the Social Security Act (the Act) requires CMS to update the conversion factor used to determine payment rates under the OPPS on an annual basis by applying the hospital outpatient department (OPD) fee schedule increase factor. The OPD fee schedule increase factor is equal to the hospital inpatient market basket percentage increase applicable to hospital discharges. Section 1833(t)(3)(F)(i) of the Act, as amended by the Affordable Care Act (ACA), requires that the OPD fee schedule increase factor be reduced by the productivity adjustment for 2012 and subsequent years. The productivity adjustment is equal to the 10-year moving average of changes in annual economy-wide, private nonfarm business multifactor productivity (MFP), which is ***0.7 percent*** for FY13. Additionally, sections 1833(t)(3)(F)(ii) and 1833(t)(3)(G)(ii) of the Act require that the OPD fee schedule increase factor be reduced by ***0.1 percent*** for CY13.

CMS will increase payment rates under the OPPS by an OPD fee schedule increase factor of ***1.8 percent*** for the CY13 OPPS. This reflects the 2.6 final estimate of the hospital inpatient market basket percentage increase, minus the proposed 0.7 percent MFP adjustment and the additional 0.1 percent reduction required by the ACA.

Hospitals that fail to meet the reporting requirements of the Hospital OQR Program will be subject to a further reduction of an additional ***2.0 percent*** from the OPD fee schedule increase factor adjustment to the conversion factor that would be used to calculate the OPPS payment rates. As a result, those hospitals would receive an OPD fee schedule increase factor of **-0.2 *percent*** (2.6 percent, which is the final estimate of the hospital inpatient market basket percentage increase, less the proposed 0.7 percent MFP adjustment, less the 0.1 percent additional adjustment, less 2.0 percent for the Hospital OQR Program reduction).

The table below reflects the CY13 OPPS final payment update calculations for hospitals that submit quality data and those that do not.

Impact of Final CY13 OPPS Updates *

Market Basket Increase	(Minus) MFP Adjustment	(Minus) ACA Reduction	**FY13 Payment Increase**
2.6	0.7	0.1	**1.8**

Impact of Final CY13 OPPS Updates (No Quality Data) *

Market Basket Increase	(Minus) MFP Adjustment	(Minus) ACA Reduction	(Minus) Hospital OQR Reduction	**FY13 Payment Increase**
2.6	0.7	0.1	2.0	**-0.2**

Conversion Factor Update

To set the OPPS conversion factor for CY13, CMS will increase the CY12 conversion factor of $70.016 by 1.8 percent. CMS will further adjust the conversion factor for CY13 to ensure that any revisions it makes to the updates for a revised wage index and rural adjustment are made on

a budget neutral basis. CMS will calculate an overall ***budget neutrality factor of 0.9998*** for wage index changes by comparing total estimated payments from its simulation model using the final FY13 IPPS wage indices to those payments using the current (FY12) IPPS wage indices, as adopted on a calendar year basis for the OPPS. Therefore, the budget neutrality factor for the rural adjustment is 1.0000. Since CMS is not making any changes to the rural adjustment policy for CY13, the **budget neutrality factor for the rural adjustment is 1.0000**.

CMS estimates that pass-through spending for both drugs and biologicals and devices for CY13 would equal approximately $74 million, which represents 0.15 percent of total projected CY13 OPPS spending. Therefore, the conversion factor is also adjusted by the difference between the 0.22 percent estimate of pass-through spending for CY12 and the 0.15 percent estimate of CY13 pass-through spending, resulting in an adjustment for CY13 of -0.07 percent.

To calculate the final CY13 reduced market basket conversion factor for those hospitals that fail to meet the requirements of the Hospital OQR Program for the full CY13 payment update, CMS will make all other adjustments discussed above, but will use a proposed reduced OPD fee schedule update factor of -0.2 percent (that is, the OPD fee schedule increase factor of 1.8 percent further reduced by 2.0 percent for failure to comply with the Hospital OQR requirements). This will result in a ***reduced conversion factor for CY13 of*** **$69.887** (a difference of -$1.426 in the conversion factor relative to those hospitals that met the Hospital OQR requirements).

The OPD fee schedule increase factor of 1.8 percent, the required wage index budget neutrality adjustment of approximately 0.9998, the cancer hospital payment adjustment of 1.0000, and the adjustment of -0.07 percent of projected OPPS spending for the difference in the pass-through spending results in a conversion factor of ***$71.313*** for CY13 for those hospitals that submit quality data.

Outpatient Outlier Threshold Policy Update

For CY13, the ***fixed-dollar threshold is $2,025.*** CMS estimates that a fixed-dollar threshold of $2,025, combined with the multiple threshold of 1.75 times the ambulatory payment classification (APC) payment rate, will allocate 1.0 percent of estimated aggregated total OPPS payments to outlier payments. For CY13, CMS will continue to make an outlier payment that equals 50 percent of the amount by which the cost of furnishing the service exceeds 1.75 times the APC payment amount when both the 1.75 multiple threshold and the final fixed-dollar threshold of $2,025 are met. The fixed-dollar threshold for 2012 was $1,900.

Finally, estimated payments for outliers remain at 1.0 percent of total OPPS payments for CY13. A portion of that 1.0 percent, an amount equal to 0.12 percent of outlier payments (or 0.0012 percent of total OPPS payments) would be allocated to community mental health centers (CMHCs) for partial hospitalization program (PHP) outlier payments

If a CMHC's cost for partial hospitalization services, paid under either APC 0172 or APC 0173, exceeds 3.40 times the payment rate for APC 0173, the outlier payment is calculated as 50 percent of the amount by which the cost exceeds 3.40 times the APC 0173 payment rate.

For hospitals that fail to meet the Hospital OQR Program requirements, CMS will continue the policy implemented in CY10, which compares the hospitals' costs to the reduced payments for purposes of outlier eligibility and payment calculation.

Adjustment for Rural SCHs and EACHs

In the CY06 OPPS final rule with comment period (70 FR 68556), CMS finalized a payment increase for rural sole community hospitals (SCHs) of 7.1 percent for all services and procedures paid under the OPPS, excluding drugs, biologicals, brachytherapy sources, and devices paid under the pass-through payment policy. This increase was made after CMS found that a difference in cost by APC existed between hospitals in rural areas and hospitals in urban areas. This adjustment for rural SCHs is budget neutral and applied before calculating outliers and copayments. CMS finalizes its CY13 proposal, without modification, to apply the 7.1 percent payment adjustment to rural SCHs, including essential access community hospitals (EACHs), for all services and procedures paid under the OPPS in CY13, excluding separately payable drugs and biologicals, devices paid under the pass-through payment policy, and items paid at charges reduced to costs. CMS continues to believe that the adjustment is appropriate for application in CY13.

CY13 Proposed PHP APC Update

After consideration of the public comments it received, CMS is finalizing its CY13 proposal, without modification, to update the four PHP APC per diem payment rates based on geometric mean cost levels calculated using the most recent claims data for each provider type. CMS notes that it will continue its efforts to explore payment reforms that will support quality and result in greater payment accuracy and reduction of fraud and abuse within the partial hospitalization program.

The updated PHP APCs geometric mean per diem costs for PHP services that CMS is finalizing for CY13 are shown below (Tables 32 and 33 of the final rule).

APC	Group Title	Final Median Per Diem Costs
0172	Level I Partial Hospitalization (3 services) for CMHCs	$87.39
0173	Level II Partial Hospitalization (4 or more services) for CMHCs	$112.82

APC	Group Title	Final Median Per Diem Costs
0175	Level I Partial Hospitalization (3 services) for hospital-based PHPs	$185.90
0176	Level II Partial Hospitalization (4 or more services) for hospital-based PHPs	$234.81

Hospital OQR Program Updates

CMS has implemented quality measure reporting programs for multiple settings of care. These programs promote higher quality, more efficient health care for Medicare beneficiaries. The quality data reporting program for hospital outpatient care (i.e., the Hospital OQR Program), has been generally modeled after the quality data reporting program for hospital inpatient services known as the Hospital Inpatient Quality Reporting (Hospital IQR) Program. Both of these quality reporting programs for hospital services have financial incentives for the reporting of quality data to CMS. For the Hospital OQR Program, CMS intends to keep the measures as adopted.

Proposed Process for Retention of Hospital OQR Program Measures Adopted in Previous Payment Determinations

In past rulemakings, CMS has proposed to retain previously adopted measures for each payment determination on a year-by-year basis and invited public comments on the proposal to retain such measures for all future payment determinations unless otherwise specified. For the purpose of streamlining the rulemaking process, beginning with this rulemaking, CMS proposed that when it adopts measures for the Hospital OQR Program beginning with a payment determination and subsequent years, these measures are automatically adopted for all subsequent year payment determinations unless it proposes to remove, suspend, or replace the measures.

After consideration of the public comments received, CMS finalized the automatic retention of Hospital OQR Program measures adopted in previous payment determinations for subsequent year payment determinations.

Suspension of One Chart-Abstracted Measure for the CY14 and Subsequent Years Payment Determinations

CMS confirms the suspension of *OP-19: Transition Record with Specified Elements Received by Discharged Patients* measure, effective with January 1, 2012, encounters until further notice because of patient safety concerns. CMS adopted the measure for the Hospital OQR Program for the CY13 payment determination, with data collection beginning with January 1, 2012, encounters. Since data collection for this measure began, concerns have been raised about the current measure specifications, including potential privacy concerns related to releasing certain elements of the transition record to a patient who is being discharged from an emergency department or to the patient's caregiver. CMS chose to suspend this measure rather than to immediately remove the measure from the program because the probability of harm occurring was relatively low, any potential harm that occurred would not be the direct result of patient care rendered at facilities, and the measure steward believed that the measure could be quickly re-specified in a manner that would mitigate the concerns raised by hospitals and stakeholders.

When NQF completes its maintenance review on this measure, and CMS has incorporated the necessary changes to the measure specifications in its measure manual, CMS anticipates being able to resume data collection, and will notify hospitals of changes in the suspension status of the measure for Hospital OQR via e-mail blast. CMS is working with the measure steward, the

AMA, to enhance OP-19 for future use. When the measure specifications have been updated and reviewed by the NQF, CMS will consider implementation of the revised measure.

Deferred Data Collection of OP-24: Cardiac Rehabilitation Measure: Patient Referral from an Outpatient Setting for the CY14 Payment Determination

In the CY12 OPPS/ASC final rule with comment period, CMS finalized *OP-24: Cardiac Rehabilitation Measure: Patient Referral from an Outpatient Setting* for CY14 payment determination, and indicated that the applicable quarters for data collection for this measure would be first and second quarter CY13. In order for CMS to adhere to this data collection schedule, it would have needed to publish the measure specifications in the July 2012 release of the *Hospital OQR Specifications Manual*. Further, in order to implement standardized data collection on a national scale, CMS would have needed to include detailed abstraction instructions for chart-based measures in its July 2012 *Specifications Manual*. These instructions were not completed and tested in time to include in the July 2012 release of the manual, which includes collection instructions for measures beginning January 1, 2013. Therefore, CMS is finalizing the deferred data collection for OP-24 from January 1, 2013, to January 1, 2014, encounters for the CY15 payment determination.

Hospital OQR Program Measures for the CY14 Payment Determination and Subsequent Years

CMS is not proposing any additional measures for the CY14 payment determination year. Readers are referred to previous OPPS/ASC final rules with comment periods for a history of measures adopted for the Hospital OQR Program, including lists of 11 measures finalized for the CY11 payment determination, 15 measures finalized for the CY12 payment determination, 23 measures finalized for the CY13 payment determination, and 26 measures finalized for the CY14 and CY15 payment determinations.

Chart-Abstracted Measure Requirements for CY14 and Subsequent Payment Determination Years

For the chart-abstracted measures for which CMS has finalized that it will collect data for the CY14 payment determination, the applicable quarters for data collection will be as follows: third quarter CY12, fourth quarter CY12, first quarter CY13, and second quarter CY13 for hospitals that are continuing participants. Newly participating hospitals would follow reporting requirements as outlined in the CY12 OPPS/ASC final rule with comment period, and in section XV.G.1.of the proposed rule. For the CY15 payment determination, CMS proposes that the applicable quarters for previously finalized chart-abstracted measures would be as follows: third quarter CY13, fourth quarter CY13, first quarter CY14, and second quarter CY14.

Quality Measures for CY15 Payment Determination

CMS is not adopting additional measures for the CY15 payment determination, and is retaining 25 of the 26 measures previously adopted for the CY14 payment determination for CY15 and subsequent year payment determinations. The table below contains the previously adopted measures which CMS is retaining for the CY14, CY15, and subsequent years payment determinations under the Hospital OQR Program.

Hospital OQR Program Measures Adopted for the CY14, CY15, and Subsequent Year Payment Determinations	
OP-1: Median Time to Fibrinolysis	
OP-2: Fibrinolytic Therapy Received Within 30 Minutes	
OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention	
OP-4: Aspirin at Arrival	
OP-5: Median Time to ECG	
OP-6: Timing of Antibiotic Prophylaxis	
OP-7: Prophylactic Antibiotic Selection for Surgical Patients	
OP-8: MRI Lumbar Spine for Low Back Pain	
OP-9: Mammography Follow-up Rates	
OP-10: Abdomen CT – Use of Contrast Material	
OP-11: Thorax CT – Use of Contrast Material	
OP-12: The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into Their Qualified/Certified EHR System as Discrete Searchable Data	
OP-13: Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low Risk Surgery	
OP-14: Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT)	
OP-15: Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache	
OP-16: Troponin Results for Emergency Department Acute Myocardial Infarction (AMI) Patients or Chest Pain Patients (with Probable Cardiac Chest Pain) Received Within 60 Minutes of Arrival	
OP-17: Tracking Clinical Results Between Visits	
OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients	
OP-19: Transition Record with Specified Elements Received by Discharged ED Patients	
OP-20: Door to Diagnostic Evaluation by a Qualified Medical Professional	
OP-21: ED- Median Time to Pain Management for Long Bone Fracture	
OP-22: ED Patient Left Without Being Seen	
OP-23: ED- Head CT Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Who Received Head CT Scan Interpretation Within 45 Minutes of Arrival	
OP-24: Cardiac Rehabilitation Patient Referral from an Outpatient Setting	
OP-25: Safe Surgery Checklist Use	
OP-26: Hospital Outpatient Volume Data on Selected Outpatient Surgical Procedures	
Procedure Category	**Corresponding HCPCS Codes**

Gastrointestinal	40000 through 49999, G0104, G0105,G0121,C9716, C9724, C9725, 0170T
Eye	65000 through 68999, 0186, 0124T, 0099T, 0017T, 0016T, 0123T, 0100T, 0176T, 0177T, 0186T, 0190T, 0191T, 0192T, 76510, 0099T
Nervous System	61000 through 64999, G0260, 0027T, 0213T, 0214T, 0215T, 0216T, 0217T, 0218T, 0062T
Musculoskeletal	20000 through 29999, 0101T, 0102T, 0062T, 0200T, 0201T
Skin	10000 through 19999, G0247, 0046T, 0268T, G0127, C9726, C9727
Genitourinary	50000 through 58999, 0193T, 58805
Cardiovascular	33000 through 37999
Respiratory	30000 through 32999

Possible Quality Measures under Consideration for Future Inclusion in the Hospital OQR Program

CMS seeks to develop a comprehensive set of quality measures to be available for widespread use for informed decision making and quality improvement in the hospital outpatient setting. Therefore, through future rules, it intends to propose new measures that help further goals of achieving better health care and improved health for Medicare beneficiaries who receive health care in hospital outpatient settings. In addition, CMS is considering initiating a call for input to assess the following measure domains: clinical quality of care; care coordination; patient safety; patient and caregiver experience of care; population/community health; and efficiency. CMS believes this approach will promote better care while bringing the Hospital OQR Program in line with other established quality reporting and pay for performance programs such as the Hospital IQR Program.

Random Selection of Hospitals for Data Validation of Chart-Abstracted Measures for CY14 Payment Determination and Subsequent Years

In the CY12 OPPS/ASC final rule with comment period, CMS adopted a policy to validate chart-abstracted patient-level data submitted directly to CMS from randomly selected hospitals for the CY13 payment determination. For the CY13 payment determination, CMS reduced the number of randomly selected hospitals from 800 to 450, and will continue this policy for the CY14 payment determination and for subsequent years. In the CY12 OPPS/ASC final rule**,** CMS also finalized its intent to select an additional 50 hospitals based on specific criteria designed to measure whether the data these hospitals have reported raises a concern regarding data accuracy. After consideration of the public comments, CMS will not include any additional targeting criteria to use in selecting the additional 50 hospitals it includes in the validation process for the CY14 payment determination or in subsequent years.

Methodology for Encounter Selection for the CY14 Payment Determination and Subsequent Years

For each selected hospital (random or targeted), CMS will continue the approach it adopted in the CY12 OPPS/ASC final rule with comment period for the CY14 payment determination and subsequent years. For CY14, for each selected hospital (random or targeted), CMS will continue

to validate up to 48 randomly selected patient encounters (12 per quarter) from the total number of encounters that the hospital successfully submitted to the OPPS clinical warehouse. If a selected hospital has submitted less than 12 encounters in one or more quarters, only those encounters available would be validated. For each selected encounter, a designated CMS contractor will request that the hospital submit the complete supporting medical record documentation that corresponds to the encounter. CMS will conduct a measures level validation by calculating each measure within a submitted record using the independently abstracted data, and then comparing this to the measure reported by the hospital; a percent agreement will then be calculated.

To receive the full OPPS OPD fee schedule increase factor for CY14, hospitals must attain at least a 75 percent reliability score, based upon the proposed validation process. CMS will use the upper bound of a two-tailed 95 percent confidence interval to estimate the validation score. If the calculated upper limit is above the required 75 percent reliability threshold, CMS would consider a hospital's data to be ''validated'' for payment purposes.CMS will calculate the validation score and use the same medical record documentation submission procedures and the same methodology it finalized for the CY12 and CY13 payment determinations. CMS will also use the same medical record documentation submission procedures finalized for the CY12 and CY13 payment determinations.

Regarding CMS's policy requiring validation of measures requiring time values, CMS agrees that requiring time values to match exactly is not realistic based on its historical experience with clinical data abstraction, the recognition that hospital clocks may vary from system to system such that the same time may be recorded differently depending on the source, and the limited clinical significance of small deviations in time. This particular concern affects the validation score for the CY14 payment determination as well as for future years. Therefore, for the CY14 payment determination and for subsequent years, CMS will not require, when scoring the following chart-abstracted measures, that these measures have matching numerator and denominator states:

- OP–18: Median Time from ED Arrival to ED Departure for Discharged ED Patients
- OP–19: Transition Record with Specified Elements Received by Discharged ED Patients (This measure is currently suspended and will not be used in the CY14 payment determination. CMS intends to confirm whether this measure will be included in future payment determinations in future rulemaking.)
- OP–20: Door to Diagnostic Evaluation by a Qualified Medical Professional
- OP–21: ED—Median Time to Pain Management for Long Bone Fracture
- OP–22: ED Patient Left Without Being Seen
- OP–23: ED—Head CT Scan Results for Acute Ischemic Stroke

Instead, for scoring of these measures, CMS will allow a 5 minute variance between the time abstracted by the hospital and that abstracted by the Clinical Data Abstraction Center.

Proposed CY12 Packaged Revenue Codes

As it did for CY12, CMS reviewed for CY13 the changes to revenue codes that were effective during CY11 for purposes of determining the charges reported with revenue codes but without healthcare common procedures coding system (HCPCS) codes that it would propose to package for CY13. CMS believes that the charges reported under the revenue codes listed in the Table 2 of the final rule continue to reflect ancillary and supportive services for which hospitals report charges without HCPCS codes. Therefore, for CY13, CMS will continue to package the costs that it derives from the charges reported without HCPCS codes under the revenue codes listed in Table 2 for purposes of calculating the geometric mean costs on which the final CY13 OPPS/ASC payment rates are based. CMS is finalizing the proposed packaged revenue codes for CY13, without modification. CMS notes that these revenue codes include only revenue codes that were in effect in CY11, the year of the claims data on which the final CY13 OPPS payment rates are based.

APC Updates

New Technology APCs

CMS generally keeps a procedure in the new technology APC to which it is initially assigned until it has collected sufficient data to enable it to move the procedure to a clinically appropriate APC. However, in cases where it finds that its original new technology APC assignment was based on inaccurate or inadequate information, or where the new technology APCs are restructured, it may, based on more recent resource utilization information (including claims data) or the availability of refined new technology APC cost bands, reassign the procedure or service to a different new technology APC that more appropriately reflects its cost. Consistent with its current policy, for CY13, CMS proposes to retain services within new technology APC groups until it gathers sufficient claims data to enable it to assign the service to a clinically appropriate APC. The flexibility associated with this policy allows CMS to move a service from a New Technology APC in less than two years if sufficient claims data are available. It also allows CMS to retain a service in a New Technology APC for more than two years if sufficient claims data upon which to base a decision for reassignment have not been collected.

There are currently three procedures described by HCPCS G-codes receiving payment through a New Technology APC: HCPCS code G0417, G0418, and G0419. For OPPS claims submitted from CY09 through CY11, the final rule claims data show very minimal claims for HCPCS code G0417, G0418, and G0419. Given the continued lack of cost data for these HCPCS codes, CMS will reassign these procedures to an APC that is appropriate from a clinical standpoint.

Specifically, CMS will reassign HCPCS G-codes G0417, G0418, and G0419 to clinical APC 0661, with a proposed APC payment rate of approximately $160 for CY13. CMS believes that all three procedures, as described by HCPCS codes G0417, G0418, and G0419, are comparable clinically to other pathology services currently assigned to APC 0661 and likely require similar resources.

The table below (Table 19 in the final rule) lists the HCPCS G-codes and associated status indicators that CMS is proposing to reassign from new technology APCs 1505, 1506, and 1508 to APC 0661 for CY13.

CY13 HCPCS Code	CY13 Short Descriptor	CY12 SI	CY12 APC	Proposed CY13 SI	Proposed CY13 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 notes that APC 0661 is the same APC to which the other HCPCS G-code for prostate needle saturation biopsy procedure, G0416 (Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 1-20 specimens), is assigned. In addition, for the CY13 update, CMS is revising the long descriptor for HCPCS code G0416 to read *"Surgical pathology gross and microscopic examination for prostate needle saturation biopsy sampling 10-20 specimens"* effective January 1, 2013. The final CY13 geometric mean cost for APC 0661 is approximately $162.

Calculation of Composite APC Criteria-Based Costs

As discussed in the CY08 OPPS/ASC final rule with comment period, CMS believes it is important that the OPPS enhance incentives for hospitals to provide only necessary, high quality care and to provide that care as efficiently as possible. For CY08, CMS developed composite APCs to provide a single payment for groups of services that are typically performed together during a single clinical encounter and that result in the provision of a complete service. Under the OPPS, CMS currently has composite policies for extended assessment and management services, low dose rate (LDR) prostate brachytherapy, cardiac electrophysiologic evaluation and ablation services, mental health services, multiple imaging services, and cardiac resynchronization therapy services. For CY13, CMS proposes to continue its composite policies for these services. The following table displays the proposed and current costs of the extended assessment and management, low dose rate (LDR) prostate brachytherapy, and cardiac electrophysiologic evaluation and ablation composite APCs.

Composite APC	CY13 Final Cost	Current Amount
8002	$453	$393
8003	$821	$721
8001	$3,348	$3,340
8000	$11,466	$11,313

The final rule's Table 4 lists the final groups of procedures upon which CMS will base composite APC 8000 for CY13.

- *Mental Health Services Composite APC (APC 0034)*
  CMS finalizes its proposal to continue the longstanding policy of limiting the aggregate payment for specified less resource-intensive mental health services furnished on the same date by a hospital to the payment for APC 01760176 (Level II Partial Hospitalization [4 or more services] for Hospital-Based PHPs), which is the maximum partial hospitalization per diem payment for a hospital for CY13. Subsequent to the publication of the CY13 OPPS/ASC proposed rule, the AMA's CPT Editorial Panel deleted 16 psychotherapy and psychiatric diagnostic evaluation CPT codes to which the mental health services composite APC methodology applies, and replaced them with 12 new CPT codes, to be effective January 1, 2013. The new and deleted CPT codes are included in Table 5 of the final rule.

- *Multiple Imaging Composite APCs (APCs 8004, 8005, 8006, 8007, and 8008)*
  For CY13, CMS will continue to calculate multiple imaging composite APC costs for CY13 pursuant to its established methodology. For the final rule with comment period, CMS was able to identify approximately 1.0 million "single session" claims out of an estimated 1.6 million potential composite cases from its rate setting claims data to calculate the final CY13 costs for the multiple imaging composite APCs. Table 6 of the rule lists the HCPCS codes that will be subject to the multiple imaging composite policy and their respective families and approximate composite APC costs for CY13. Table 7 lists the OPPS imaging family services that overlap with HCPCS codes on the CY13 bypass list. CMS notes that it mistakenly did not include CPT code 70547 (Magnetic resonance angiography, neck; without contrast material(s)) on this list in the proposed rule, but is adding it to this list for the final rule because it is part of the magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA) with and without contrast imaging family and is also on the CY13 bypass list.

Geometric Mean-Based Relative Payment Weights

For CY13, CMS will shift the basis for the CY13 APC relative payment weights that underpin the OPPS from median costs to geometric means based costs. Payment weights on geometric mean costs will specifically include the CMHC and hospital-based PHP APCs, which were previously based on median per diem costs. The use of geometric mean-based costs also would allow CMS to detect changes in the cost of services earlier, because changes in cost often diffuse into the industry over time as opposed to impacting all hospitals equally at the same time.

<u>Extended Assessment and Management Composite APCs</u>

For CY13, CMS is finalizing its proposed policy, without modification, to calculate the costs for APCs 8002 and 8003 using the same methodology that it used to calculate the costs for composite APCs 8002 and 8003 for the CY08 OPPS. ***The final CY13 cost resulting from this methodology for composite APC 8002 is approximately $453***, which was calculated from 19,028 single and "pseudo" single claims that met the required criteria. ***The final CY13 cost for composite APC 8003 is approximately $821***, which was calculated from 284,861 single and "pseudo" single claims that met the required criteria.

Proposed Pass-through Payments for Devices

Under the OPPS, a category of devices are eligible for transitional pass-through payments for at least 2, but not more than 3 years. This pass-through payment eligibility period begins with the first date on which transitional pass-through payments may be made for any medical device that is described by the category. Device pass-through categories C1830 and C1840 were established for pass-through payments on October 1, 2011, and will reach the end of their eligibility term as of the end of CY13. Also, device pass-through category C1886 was established for pass-through payments on January 1, 2012, and will also reach the end of its eligibility term as of the end of CY13.

Therefore, pass-through payment eligibility for device category codes C1830, C1840, and C1886 will expire as of December 31, 2013, and the device costs will be packaged with the respective procedures with which these devices are billed. Furthermore, CMS maintains its previous decision to package the costs of HCPCS code C1749 device (retrograde colonoscope or third eye retroscope) with the procedures with which it is billed, as of January 1, 2013.

Proposed Drugs and Biologicals with Expiring Pass-through Status in CY12

CMS is finalizing its proposal to expire the pass-through status of the 23 drugs and biologicals listed in Table 31 of the final rule. All of these drugs and biologicals will have received OPPS pass-through payment for at least two years and no more than three years by December 31, 2012. These drugs and biologicals were approved for pass-through status on or before January 1, 2011.

CMS will assign HCPCS code J7183 to status indicator "K" for CY13. This HCPCS code was erroneously assigned to a status indicator of "N" for the CY13 OPPS/ASC proposed rule. The per day cost for HCPCS code J7183 for this final rule with comment period exceeds the $80 packaging threshold for CY 2013.

Table 31 lists the drugs and biologicals for which pass-through status will expire on December 31, 2012, the status indicators, and the assigned APCs for CY13.

TABLE 31.—PROPOSED DRUGS AND BIOLOGICALS FOR WHICH PASS-THROUGH STATUS WILL EXPIRE DECEMBER 31, 2012

CY13 HCPCS Code	CY13 Long Descriptor	CY13 SI	CY13 APC
C9275	Injection, hexaminolevulinate hydrochloride, 100 mg, per study dose	N	N/A

C9367	Skin substitute, Endoform Dermal Template, per square centimeter	K	9367
J0221	Injection, alglucosidase alfa, (lumizyme), 10 mg	K	1413
J0588	Injection, incobotulinumtoxin A, 1 unit	K	9278
J0597	Injection, C-1 esterase inhibitor (human), Berinert, 10 units	K	9269
J0775	Injection, collagenase clostridium histolyticum, 0.01 mg	K	1340
J0840	Injection, crotalidae polyvalent immune fab (ovine), up to 1 gram	K	9274
J0897	Injection, denosumab, 1 mg	K	9272
J1290	Injection, ecallantide, 1 mg	K	9263
J1557	Injection, immune globulin (Gammaplex), intravenous, nonlyophilized (e.g. liquid), 500 mg	K	9270
J1741	Injection, ibuprofen, 100 mg	N	N/A
J3095	Injection, telavancin, 10 mg	K	9258
J3262	Injection, tocilizumab, 1 mg	K	9264
J3357	Injection, ustekinumab, 1 mg	K	9261
J3385	Injection, velaglucerase alfa, 100 units	K	9271
J7183	Injection, von Willebrand factor complex (human), Wilate, per 100 IU VWF: RCO	K	1352
J7335	Capsaicin 8% patch,per 10 square centimeters	K	9268
J8562	Fludarabine phosphate, oral, 10 mg	K	1339
J9043	Injection, cabazitaxel, 1 mg	K	1339
J9302	Injection, ofatumumab, 10 mg	K	9260
J9307	Injection, pralatrexate, 1 mg	K	9259
J9315	Injection, romidepsin, 1 mg	K	9265
Q2043	Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion	K	9273

Cancer Hospitals

Payment Adjustment

For CY13, CMS will continue its policy to provide additional payments to cancer hospitals so that each cancer hospital's final payment-to-cost ratio (PCR) is equal to the weighted average PCR for the other OPPS hospitals using the most recent submitted or settled cost report data that were available at the time of the final rule with comment period. Based on those data, a target **PCR of 0.91** will be used to determine the CY13 cancer hospital payment adjustment to be paid at cost report settlement. That is, the payment amount associated with the cancer hospital

payment adjustment to be determined at cost report settlement will be the additional payment needed to result in a PCR equal to 0.91 for each cancer hospital. Table 9 of the final rule indicates the estimated percentage increase in OPPS payments to each cancer hospital for CY13 due to the cancer hospital payment adjustment policy.

Conversion Factor Update

CMS will continue its previously established policies for implementing the cancer hospital payment adjustment. The difference in the CY13 estimated payments as a result of applying the CY13 cancer hospital payment adjustment relative to the CY12 final cancer hospital payment adjustment does not have a significant impact on the budget neutrality calculation. Therefore, CMS will apply a budget neutrality adjustment factor of 1.0000 to the conversion factor to ensure that the cancer hospital payment adjustment is budget neutral.

Supervision of Hospital Outpatient Therapeutic Services

In the final rule, CMS clarifies the application of the supervision regulations to physical therapy, speech-language pathology, and occupational therapy services that are furnished in OPPS hospitals and critical access hospitals (CAHs). In the CY12 OPPS/ASC final rule with comment period, CMS extended through CY12 the notice of nonenforcement of the requirement for direct supervision of outpatient therapeutic services furnished in CAHs and small rural hospitals having 100 or fewer beds.

CMS extended this enforcement instruction to contractors for another year, through CY12, to allow time for the initiation of supervision reviews by the Advisory Panel on Hospital Outpatient Payment (the Panel), which began in early 2012, and is continuing in accordance with the provisions of the CY12 OPPS/ASC final rule with comment period. In the CY13 OPPS/ASC proposed rule, CMS requested that CAHs and small rural hospitals submit to CMS for potential evaluation by the Panel at its summer meeting any services for which they anticipate difficulty complying with the direct supervision standard in CY13.

In order to give hospitals additional opportunity during CY12 to become familiar with the new submission and review process at the summer Panel meeting, and to allow hospitals time to meet the required supervision levels for the services that would be considered for CY13, CMS indicated that it anticipated extending the nonenforcement instruction one additional year through CY13. This additional year, which is expected to be the final year of the extension, will provide additional opportunities for stakeholders to bring their issues to the Panel, and for the Panel to evaluate and provide CMS with recommendations on those issues.

The Panel held its second meeting on supervision levels for outpatient therapeutic services in August 2012, and considered several stakeholder requests for a reduction in the minimum required level of supervision for certain services. CMS is currently reviewing public comments on the agency's preliminary decisions regarding supervision levels for these services based upon the Panel's recommendations. CMS will issue its final decisions on these services prior to January 1, 2013, on its web site.

Ambulatory Surgical Centers

Payment Rate Updates

The ASC payment system is updated annually by the consumer price index for all urban consumers (CPI-U). For CY13, CMS is increasing payment rates under the ASC payment system by **0.6 percent**. This increase is based on a projected CPI-U update of **1.4 percent** minus an MFP adjustment required by the ACA that is projected to be 0.8 percent.

The following table displays the CY13 proposed rate update calculations under the ASC payment system.

CPI-U update	(Minus) MFP Adjustment	**MFP-Adjusted CPI-U Update**
1.4 %	0.8%	**0.6 %**

The final ASC conversion factor of **$42.917** is the product of the CY12 conversion factor of $42.627 multiplied by the wage index **budget neutrality adjustment of 1.0008** in addition to the MFP-adjusted CPI-U payment update of **0.6** percent.

Based on this update, CMS estimates that total ASC payments for CY13, including beneficiary cost-sharing and estimated changes in enrollment, utilization, and case-mix, will be approximately **$4.074 billion**, an increase of approximately **$310 million** compared to estimated CY12 payments.

Proposed Payment Reduction for ASCs that Fail to Meet the ASCQR Program Requirements

The HHS secretary is authorized to implement the revised ASC payment system "in a manner so as to provide for a reduction in any annual update for failure to report on quality measures." Any ASC that does not submit quality measures will incur a 2.0 percent reduction to any annual increase provided under the revised ASC payment system for such year. This reduction would apply beginning with the CY14 payment rates. A reduction for one year cannot be taken into account in computing any annual increase factor for a subsequent year. To implement the requirement to reduce the annual update for ASCs that fail to meet the ASC quality reporting (ASCQR) Program requirements, CMS is proposing to calculate two conversion factors: a full update conversion factor and an ASCQR Program reduced update conversion factor. CMS will calculate the reduced national unadjusted payment rates using the ASCQR Program reduced update conversion factor that would apply to ASCs that fail to meet their quality reporting requirements for that calendar year payment determination. The application of the 2.0 percent reduction to the annual update may result in the update to the ASC payment system being less than zero prior to the application of the MFP adjustment.

ASCQR Program Quality Measures

In the CY12 OPPS/ASC final rule with comment period, CMS finalized its proposal to implement the ASCQR Program beginning with the CY14 payment determination and adopted measures for the CY14, CY15, and CY16 payment determinations. CMS also finalized its policy to retain measures from one calendar year payment determination to the next so that measures adopted for a previous payment determination year would be retained for subsequent years.

CY14 Final Measures

CMS adopted the following five claims-based measures for the CY14 payment determination for services furnished between October 1, 2012, and December 31, 2012:

- Patient Burns (NQF #0263)
- Patient Fall (NQF #0266)
- Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant (NQF #0267)
- Hospital Transfer/Admission (NQF #0265)
- Prophylactic Intravenous (IV) Antibiotic Timing (NQF #0264)

CY15 Final Measures

For the CY15 payment determination, CMS retained the five claims-based measures it adopted for the CY14 payment determination and adopted the following two structural measures:

- Safe Surgery Checklist Use
- ASC Facility Volume Data on Selected ASC Surgical Procedures

CMS specified that reporting for the structural measures would be between July 1, 2013, and August 15, 2013, for services furnished between January 1, 2012, and December 31, 2012, using an online measure submission web page available at: https://www.QualityNet.org.

CMS did not specify the data collection period for the five claims-based measures for the CY15 payment determination.

CY16 Final Measures

For the CY16 payment determination, CMS finalized the retention of the seven measures from the CY15 payment determination (five claims-based measures and two structural measures). It also adopted the following NQF-endorsed measure, for a total of eight measures:

- Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431), a process of care, healthcare-associated infection measure

CMS specified that data collection for the influenza vaccination measure would be via the National Healthcare Safety Network from October 1, 2014, through March 31, 2015. CMS did not specify the data collection period for the claims-based or structural measures. In the CY13 OPPS/ASC proposed rule, considering the time and effort required to develop, align, and implement the infrastructure necessary to collect data on the ASCQR Program measures and make payment determinations, and the time and effort required on the part of ASCs to plan and prepare for quality reporting, CMS did not propose to delete or add any quality measures for the ASCQR Program for the CY14, CY15, and CY16 payment determination years, or to adopt quality measures for subsequent payment determination years. In the final rule, CMS provides a table listing of the ASCQR Program quality measures that were previously finalized in the CY12 OPPS/ASC final rule with comment period.

ASC Program Measurement Set Adopted in Previous Rulemaking	
ASC-1: Patient Burn*	
ASC-2: Patient Fall*	
ASC-3: Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant*	
ASC-4: Hospital Transfer/Admission*	
ASC-5: Prophylactic Intravenous (IV) Antibiotic Timing*	
ASC-6: Safe Surgery Checklist Use**	
ASC-7: ASC Facility Volume Data on Selected ASC Surgical Procedures**	
Procedure Category	**Corresponding HCPCS Codes**
Gastrointestinal	40000 through 49999, G0104, G0105,G0121,C9716, C9724, C9725, and 0170T
Eye	65000 through 68999, G0186, 0124T, 0099T, 0017T, 0016T, 0123T, 0100T, 0176T, 0177T, 0186T, 0190T, 0191T, 0192T, 76510, and 0099T
Nervous System	61000 through 64999, G0260, 0027T, 0213T, 0214T, 0215T, 0216T, 0217T, 0218T, and 0062T
Musculoskeletal	20000 through 29999, 0101T, 0102T, 0062T, 0200T, and 0201T
Skin	10000 through 19999, G0247, 0046T, 0268T, G0127, C9726, and C9727
Genitourinary	50000 through 58999, 0193T, and 58805
ASC- 8: Influenza Vaccination Coverage among Healthcare Personnel ***	

* = CY14 Final Measure; ** = CY15 Final Measure; *** = CY16 Final Measure

ASC Measure Topics for Future Consideration

In the CY13 OPPS/ASC proposed rule CMS stated that it intends to propose new measures in order to select quality measures that address clinical quality of care, patient safety, and patient and caregiver experience of care. CMS invited public comment specifically on the inclusion of procedure-specific measures for cataract surgery, colonoscopy, endoscopy, and for anesthesia-related complications in the ASCQR Program measure set. Commenters either supported or suggested the inclusion of the following measure topics under the ASCQR Program:

- Patient Experience of Care
- Surgical Site Infection
- Surgical Complications
- Anesthesia-Related Complications
- Otolaryngology
- Gastroenterology
- Equipment Reprocessing
- Adverse Events after Discharge

Form, Manner, and Timing for Claims-Based Measures for the CY14 and CY15 Payment Determination and Subsequent Years

To be eligible for the full CY14 ASC annual payment update, an ASC must submit complete data on individual quality measures through a claims-based reporting mechanism by submitting the appropriate quality data codes (QDCs) on the ASC's Medicare claims. The data collection period for the CY14 payment determination is established as the Medicare fee-for-service ASC claims submitted for services furnished between October 1, 2012, and December 31, 2012. In the FY13 IPPS/LTCH PPS proposed rule, CMS proposed that claims for services furnished between these dates would have to be paid by the administrative contractor by April 30, 2013, to be included in the data used for the CY14 payment determination. CMS believes that this claim paid date would allow ASCs sufficient time to submit claims while allowing sufficient time for CMS to complete required data analysis and processing to make payment determinations and to supply this information to administrative contractors.

For the CY15 payment determination and subsequent payment determination years, an ASC must submit complete data on individual claims-based quality measures through a claims-based reporting mechanism by submitting the appropriate QDCs on the ASC's Medicare claims. The data collection period for such claims-based quality measures will be for the calendar year two years prior to a payment determination and the claims for services furnished in each calendar year will have to be paid by the Medicare Administrative Contractor by April 30 of the following year of the ending data collection time period to be included in the data used for the payment determination.

Thus, for example, for the CY15 payment determination, the data collection period would be claims for services furnished in CY13 (January 1, 2013, through December 31, 2013), which are paid by the administrative contractor by April 30, 2014.

Electronic Health Record (EHR) Incentive Program

For the EHR Incentive Program, CMS is extending the 2012 Medicare EHR Incentive Program Electronic Reporting Pilot for Eligible Hospitals and CAHs through 2013, exactly as finalized for 2012. CMS recently issued a final rule for Stage 2 of the Medicare and Medicaid EHR Incentive Programs.

Regulatory Impact Analysis

CMS estimates that the effects of the proposed OPPS payment provisions will result in expenditures exceeding $100 million in any 1 year, and that the total increase from the proposed changes in this proposed rule in expenditures under the OPPS for CY13 compared to CY12 would be approximately ***$600 million***. Considering its estimated changes in enrollment, utilization, and case-mix, CMS estimates that the OPPS expenditures for CY13 would be approximately ***$4.571 billion*** relative to CY12. CMS estimates the total increase (from changes in the final rule with comment period as well as enrollment, utilization, and case-mix changes) in expenditures under the ASC payment system for CY13 compared to CY12 will be approximately ***$189 million***.

Other Information
This final rule with comment period is effective on January 1, 2013.

CMS will accept comments on the final rule until December 31, 2012.

Publication Information
Read the final rule, published in the November 15, 2012, *Federal Register*.