CY 2012 OPPS Update

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The final rule for calendar year 2012 Hospital Outpatient Prospective Payment System (OPPS) was released on November 30, 2011. The rule went into effect for outpatient hospital-based services January 1, 2012.

This article outlines the updates in the final rule.

Financial Impact

The updated conversion factor for OPPS in 2012 is $70.016 for hospitals that meet the reporting requirements of the Hospital Outpatient Quality Reporting program. This is a 1.9 percent increase of the outpatient department fee schedule. The increase was calculated by using the 3 percent hospital market basket increase less 1 percentage point for the multifactor productivity adjustment and less the 0.1 percentage point adjustment required by the Affordable Care Act, which established a reduction to the fee schedule increase factor for each year through 2019.

For hospitals that are unable to meet the data-reporting requirements for the Hospital Outpatient Quality Reporting program, the adjusted conversion factor is $68.616.

Outlier Calculation

An outlier payment will continue to be provided when the cost of furnishing the service exceeds 1.75 times the APC payment amount and exceeds the APC payment rate plus a $1,900 fixed-dollar threshold. This is a decrease from the CY 2011 fixed-dollar threshold of $2,025.

The additional outlier payment will be equal to 50 percent of the costs exceeding these two thresholds.

Composite APC-Cardiac Resynchronization Therapy Defibrillator

The Centers for Medicare and Medicaid Services (CMS) will recognize CPT codes 33225, Insertion of cardiac venous lead with defibrillator or pacemaker generator (add on code), and 33249, Insertion/replacement of defibrillator and leads, as a single, composite service when the procedures are performed on the same date of service.

These CPT codes were assigned to APC 0108 with an associated status indicator of Q3 (codes that may be paid through a composite APC) because CMS elected not to create a new composite APC for cardiac resynchronization therapy defibrillator services.

The Inpatient/Outpatient Code Editor will identify the combination of these two CPT codes and make a single composite payment.

CMS made provisions for cases where the two CPT codes are not reported on the same day. When CPT code 33249 is reported without CPT code 33225, CPT code 33249 will be assigned to APC 0108. If CPT code 33225 is reported alone, then it will be assigned to APC 0655.

A new claim-processing edit is to be developed to return claims to providers when CPT code 33225 is not billed with one of the following CPT codes: 33206–33208, 33212–33214, 33216, 33217, 33222, 33233–33235, 33240, or 33249.

New Technology APCs

CMS determined that HCPCS codes G0417, G0418, and G0419 would remain in new technology APCs. There has been minimal activity for these codes in CY 2009 and CY 2010. Per CMS policy, services may remain in new technology APCs longer than two years until sufficient data have been gathered to determine the clinically appropriate APC. In 2012 these codes have been reassigned to different new technology APCs based on clinical and resource factors.

New APCs

Although it did not adopt the recommendation in 2011, CMS did reconfigure the APCs for upper gastrointestinal procedures into three APCs rather than just two (APC 0141 and 0422) in the CY 2012 final rule. APC 0419, Level II Upper GI Procedures, was created, and APC 0422 was renamed "Level III Upper GI Procedures." Consequently, the upper GI procedure CPT codes have been reallocated within these three APCs.

New APCs were created for combined abdominal and pelvis computed tomography (CT) without contrast (APC 0331) and combined abdominal and pelvis CT with contrast (APC 0334). CPT code 74176 will be assigned to composite APC 8005 when it is present with another CT procedure code for a different body region. When CPT code 74177 or 74178 is present with another CT procedure code for a different body region, composite APC 8006 will be assigned.

Drug Payment Packaging

For CY 2012, CMS has set the drug packaging threshold at $75. CMS also addressed fluctuations in the average sales price plus percent (ASP+X) redistribution amount for separately payable drugs. CMS identified that there was a 1 percentage point decline between the proposed rule and final rule in this methodology as a result of more complete cost and claims data becoming available. CMS noticed that this had also occurred in previous years.

To address this variance, the redistribution proportion of overhead cost for coded and uncoded packaged drugs will be held constant rather than redistributing a fixed dollar amount. As a result, separately payable drugs will be paid at ASP+4 percent for 2012. CMS will also pay for separately payable therapeutic radiopharmaceuticals at ASP+4 percent using the same ASP+X methodology as described above for nonpass-through separately payable drugs and biologicals.

Inpatient-Only Procedures

Based on recommendations from the APC panel and public comment, CMS eliminated the following 10 procedures from the inpatient-only list for CY 2012:

- 0184T, Excision of rectal tumor, transanal endoscopic microsurgical approach (i.e., TEMS), including muscularis propria (i.e., full thickness)
- 20930, Allograft, morselized, or placement of osteopromotive material, for spine surgery only (list separately in addition to code for primary procedure)
- 20931, Allograft, structural, for spine surgery only (list separately in addition to code for primary procedure)
- 21346, Open treatment of nasomaxillary complex fracture (Lefort II type); with wiring and/or local fixation
- 22551, Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2
- 22554, Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2
- 35045, Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, radial or ulnar artery
- 43281, Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh
- 43770, Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (e.g., gastric band and subcutaneous port components)
- 54650, Orchiopexy, abdominal approach, for intraabdominal testis (e.g., Fowler-Stephens)

Hospital Outpatient Supervision

CMS created an avenue for the evaluation of hospital outpatient supervision requirements for therapeutic services for critical access hospitals and small rural PPS hospitals by adding four new members to the APC panel. Two members will be representatives for critical access hospitals, and the other two members will represent small rural PPS hospitals.

The APC panel members will make recommendations for outpatient therapeutic services with regard to the appropriate level of supervision, whether it is general, direct, or personal supervision.

The notice of nonenforcement for critical access hospitals and small rural hospitals for direct supervision of outpatient therapeutic services will be extended through 2012. This extension will provide the APC panel with an opportunity to assess the need for changes in required supervision levels for some services as well as allow facilities time to comply with the appropriate supervision standard.

Hospital Outpatient Quality Reporting Program

CMS finalized three new measures that will affect CY 2014 payment determination. The measures include:

- Cardiac Rehabilitation: Patient Referral from an Outpatient Setting (chart-abstracted measure)
- Safe Surgical Checklist Use (structural measure)
- Hospital Outpatient Volume Data on Selected Outpatient Surgical Procedures (structural measure)

There are a total of 26 measures for CY 2014 and CY 2015 payment determinations, which include the three measures adopted above. Hospitals that do not successfully report data under the Hospital Outpatient Quality Reporting program are subject to a 2 percentage point reduction in payment.

Finally, the rule revises the number of hospitals that will be randomly selected to validate Hospital Outpatient Quality Reporting data submission, reducing it from 800 hospitals to 450. CMS writes that it has observed consistently high levels of data accuracy from hospitals in the past and thus believes it can reduce future sample size without compromising accuracy. CMS also finalized a policy that will select up to 50 hospitals for validation review based on targeted criteria.

Reference

Centers for Medicare and Medicaid Services. "Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment; Ambulatory Surgical Center Payment; Hospital Value-Based Purchasing Program; Physician Self-Referral; and Patient Notification Requirements in Provider Agreements; Final Rule." www.gpo.gov/fdsys/pkg/FR-2011-11-30/html/2011-28612.htm.

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