CY 2013 OPPS Update

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As 2012 drew to a close, US healthcare facilities began the daunting task of reviewing the Centers for Medicare and Medicaid Services' (CMS) hospital outpatient prospective payment system (OPPS) update to ensure their chargemaster and systems were up-to-date with the 2013 changes. The final rule for calendar year (CY) 2013 was released on November 15, 2012 and became effective on January 1, 2013.

Conversion Factor

The CY 2013 OPPS final rule revealed a conversion factor increase of 1.8 percent. The conversion factor is the dollar amount used to multiply the relative weights in order to determine a payment. For hospitals that meet the outpatient quality reporting requirements, the conversion factor is $71.313. Any hospital that does not meet the outpatient quality reporting requirements must use the lower conversion factor of $69.887.

Determining Changes to HCPCS Codes

In "Addendum B" of the OPPS final rule, it is easy to determine if a HCPCS code's APC status was modified for the calendar year. For any codes that are active in the current or following calendar year, there is a comment indicator (CH) that alerts the reader to a change.

A sort of Addendum B's column C shows 654 HCPCS codes that had some type of change for CY 2013, represented by the CH comment indicator. The changes may include new codes with a payment, an APC assignment change, APC payment increase or decrease, eliminated payments, status indicator changes, or deleted codes.

Addendum B is available for review on the CMS OPPS final rule website: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html.

Geometric Mean-Based Relative Payment Weights

CMS acknowledges that under the statute the OPPS payments may be based on either the mean or median costs of services within an APC group. For CY 2013, CMS decided to use the geometric mean costs for the first time instead of using the median costs. CMS analysis has shown this change should only have a limited payment impact for most providers. Some providers may see a payment gain while others may see a payment loss. This will all depend on the provider's service mix. CMS states in the *Federal Register* that "geometric means better encompass the variation in costs that occur when 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."

Rural Hospital Adjustment

CMS finalized their proposal to continue the policy of a budget-neutral 7.1 percent payment adjustment for rural sole community hospitals and essential access community hospitals. This payment is for all services and procedures paid under the OPPS, excluding separately payable drugs and biological devices paid under the pass-through payment policy, and items paid at reduced costs.

Packaged Drugs and Pass-Through Status

The drug packaging threshold was raised from $75 to $80. Any drug with a mean cost per day that was less than $80 is packaged. Twenty-three drugs and biologicals lost their pass-through status on December 31, 2012. A full list of these drugs and biologicals is represented in "Table 31.-Drugs and Biologicals For Which Pass-Through Status Will Expire December 31, 2012," available in the *Federal Register* at www.gpo.gov/fdsys/pkg/FR-2012-11-15/pdf/2012-26902.pdf. Each one has been assigned a status indicator of K, Non-Pass-Through Drugs and Biologicals, which provides a separate payment under OPPS and groups to an APC. However there is one exception for code C9275, Injection of hexaminolevulinate hydrochloride. This code was assigned a status indicator of N, indicating it is always packaged.

The OPPS policy states a category of devices must be eligible for the pass-through payment for at least two years but less than three years. For CY 2013, the device pass-through payment will expire for C1749, Endoscope, retrograde imaging/illumination colonoscope device (implantable).

The costs will be packaged into the costs of the procedure that is utilizing the device. There are currently three device categories eligible for pass-through payment: C1830, Powered bone marrow biopsy needle; C1840, Lens, intraocular (telescopic); and C1886, Catheter, extravascular tissue ablation, any modality (insertable). These three devices will become ineligible for pass-through payment on December 31, 2013 in accordance with the OPPS policy. Contrary to popular belief, these HCPCS codes do not expire when the pass-through status expires. The HCPCS codes remain active but the costs are packaged with the procedures.

Inpatient Only List

There was only one procedure removed from the inpatient only list for CY 2013. CPT code 22856, Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection), single interspace, cervical, will now be paid through the OPPS for patients that receive this procedure on an outpatient basis. There are 1,735 procedures on the inpatient only list for CY 2013. This is found in Addendum E of the OPPS final rule, available online at http://www.cms.gov/apps/ama/license.asp?file=/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/CMS-1589-FC-Addenda.zip.

Some Areas Unaffected by Update

There are a few areas in the OPPS rule that were unaltered for CY 2013. The first area is outlier payments. These continue to be based on a two-threshold model with the multiplier threshold set at 1.75 and the fixed dollar threshold set at $2,025. The 2012 outlier payment policy was carried over for 2013.

In addition, there were no new composite ambulatory payment classifications (APCs) in the final rule. There are currently 10 composite APCs that provide a single payment for a specific combination of services that would otherwise be separately payable if not provided together. The last addition to the composite APCs was APC 0108, Cardiac Resynchronization Therapy in CY 2012.

Additionally, there are no new measures for the Hospital Outpatient Quality Reporting Program for CY 2013.

To view a full list of CY 2013 OPPS changes, visit the CMS website at www.cms.gov for the complete OPPS Final Rule. The changes mentioned above represent only highlights of the many changes required in 2013.

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." *Federal Register*. Vol. 77, No. 221. November 15, 2012. http://www.gpo.gov/fdsys/pkg/FR-2012-11-15/pdf/2012-26902.pdf.

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