First Annual Hospital OPPS Update Published

by Dan Rode, MBA, FHFMA

The Health Care Financing Administration (HCFA) published its "annual" update to the hospital outpatient prospective payment system (OPPS) as an "interim final rule with comment" in the November 13, 2000, Federal Register.[1] Due to delays in the original implementation of this new PPS program and the legal requirement to annually update the system on January 1, HFCA was unable to publish the rule with the usual proposed and then final rule segments. Accordingly, those who wish to comment have until January 12, 2001. If HCFA then decides to make changes in the final rule, they will be effective retroactively to January 1, 2001.

Although this notice included a number of holdover items from other notices since the OPPS program was introduced in April 2000, the interim final rule is very similar to the DRG updates that have applied to Medicare inpatient services for many years.[2] The rule includes how annual changes in CPT and HCFA Common Procedure Coding System (HCPCS) codes will affect services rendered in calendar year 2001. HCFA also announced the usual changes in how it will pay for services under its ambulatory payment classification (APC) system and outlier and pass-through changes.

Changes to Note

In its first update, HCFA addresses several changes related to the APC group supporting codes. Of the 936 new codes added, 645 codes were designated "C" codes for inpatient procedures. HCFA also indicated that it will use the status indicator code "D" to show codes that had been deleted. However, there were no deleted codes in this announcement. In the future, should a non-C code be deleted in the annual update, there will be a three-month grace period in which they will still be recognized. HCFA indicated that deletions of C codes could occur quarterly and without a grace period.

Several of the APCs are revised to correct errors and provide greater consistency. These revisions will not affect coding, but they could affect reimbursement. Due to revisions or corrections of errors, 111 codes were changed. Eighty-seven device-related codes were also changed. Further, 56 codes were changed to reflect inpatient codes being moved to an outpatient setting (12 were included in the August 2000 update) based on medical discussion on where procedures could best be provided. An additional seven inpatient codes were also changed due to procedures affected by device. Other changes were due to the "two-times" rule, newly covered codes, and pass-through requests for drugs.

Inpatient Versus Outpatient Procedures

Determining whether a procedure could be performed on an outpatient or inpatient basis continues to be an issue. HCFA notes that "in some instances, requests for removing a particular procedure from the inpatient list may have resulted from a misunderstanding about appropriate coding. Less invasive versions of the procedure on the inpatient list may be in an APC. The presence of certain thoracoscopies on the inpatient list, for example, does not mean that no thoracoscopy will be paid under the outpatient prospective payment system."

The rule also includes a statement from HCFA that, "because of the rapid advance in technology and surgical techniques...we believe that if procedures have been assigned APCs, we should not reverse that status unless it becomes obvious that we have made an error." HCFA goes on to state that beginning in April 2001, it will revise the inpatient list at least quarterly to better reflect changes in medical practice that permit procedures previously performed only in an inpatient setting to be "safely and effectively performed in an outpatient setting," if warranted.

Next Steps for HIM Professionals

HIM professionals responsible for maintenance duties related to the APC system or a facility's chargemaster should review the Federal Register for any changes needed starting January 1, 2001. Professionals working with clinicians who desire to see a change in the "inpatient only" listing or changes in regard to pass-through exceptions should contact their facilities' Medicare

fiscal intermediary or the regional HCFA office. Depending on the procedure, device, or pharmaceutical in question, significant documentation will be required to support the request.

As the OPPS system becomes part of the routine for providers and HCFA, updates, notices of proposed rule making, and final notices will adhere to a more organized process. To comment on the update, mail one original and three copies to HCFA, Department of Health and Human Services, Attention: HCFA-1005-IFC, P.O. Box 8013, Baltimore, MD 21244-8013 by January 12, 2001.

Additional Resources

Unlike changes in the DRG system, HCFA does not provide as much detail regarding changes made. A "Summary of Changes to APCs" is included in the November 13, 2000, Federal Register on pages 67825-26, but users will have to go to Addendum B-Hospital Outpatient Department (HOPD) Payment Status by HCPCS Code and Related Information, on pages 67844-68005, to see the detailed changes. Addendum E-CPT Codes Which Will Be Paid Only As Inpatient Procedures (Calendar Year 2001) is located on pages 68005-13. Hard copies of the Federal Register are available at regional federal library repositories and through the Superintendent of Documents at (202) 515-1800. Copies can take up to 12 weeks to be delivered.

The OPPS Medicare Web site is also provides helpful information, including a listserv, and is located at www.hcfa.gov/medicare/hopsmain.htm.

Notes

1. The November 13, 2000, Federal Register is available at www.access.gpo.gov/su_docs/fedreg/a001113c.html.
2. The April 7, 2000, Federal Register is available at www.access.gpo.gov/su_docs/fedreg/a000407c.html.

Inpatient Rehabilitation Facilities see PPS

Will CMGs, RICs, and FIMs be part of your daily lexicon? If you work in an inpatient rehabilitation facility (IRF) or unit and treat Medicare patients, it's time to get acquainted with these abbreviations. The Health Care Financing Administration (HCFA) published a proposed rule on a Medicare prospective payment system (PPS) for inpatient rehabilitation facilities (IRF) in the November 3, 2000, Federal Register. [1]

HCFA is asking for comments on these proposed rules by January 2, 2001, and plans that some components of the rule become effective for some IRFs on April 1, 2001. Based on the 1997 Balanced Budget Act requirements, HCFA is proposing to implement a PPS that will replace the current "reasonable cost-based" payment system. The new PPS will use information from a patient assessment instrument to classify patients into distinct groups based on clinical characteristics and expected resource needs. Separate payments will be calculated for each group with additional case and facility level adjustments applied.

New Patient Assessment Tool

HCFA proposes to require affected facilities to complete the MDS-PAC (minimum data set for post-acute care) instrument for all Medicare patients admitted or discharged on or after April 1, 2001. Such an assessment would be completed on the fourth, 11th, 30th, and 60th day from the admission date of a Medicare patient and upon discharge. According to HCFA, "in general, a three-day observation period would be required prior to the completion of the MDS-PAC." MDS-PAC data taken on the fourth day would be used to determine the appropriate classification into a case mix group (CMG) for payment.

HCFA envisions that the MDS-PAC data will also "implement a system to monitor the quality of care furnished to Medicare patients and ensure that appropriate case mix and other adjustments can be made to the proposed patient classification system." A computerized MDS-PAC data collection system will be developed and facilities will be required to input the data into this system, which consists of grouper and data transmission software packages.

When the patient is discharged, the Medicare claim form will be completed with the appropriate CMG indicated, though the process for this has not been finalized. Like other PPS programs, there will be a considerable number of Medicare program memorandums sent out with instructions.

HCFA goes into considerable detail to describe the components and rationale for MDS-PAC, including combining the attributes of the MDS/RAI and FIM-FRG (functional independence measurement-function related group). An appendix to the proposed rule lists the first version of the MDS-PAC, but HCFA notes in detail the changes and testing that will occur before the final rule. Whether such testing and comments would be enough to delay the April deadline is unknown. Like its SNF cousin, MDS-PAC will create a significant data set with which HIM professionals must be comfortable.

Along with the assessment tool, HCFA is concerned with the assessment process. Interested parties should consider the effect on the IRF's routine. Like the SNF and home health rules, the IRF-PPS proposal also includes rules covering encoding and specific rules related to patients that may be in-house on the day the rule takes effect. There will be penalties for late assessments and encoding. In addition, to receive payment for the service furnished, the authorized clinician must inform the Medicare inpatient of certain rights with respect to the MDS-PAC assessment prior to performing the assessment.

Patient Classification Methods and Payment Rates

The CMGs under this proposal will classify patient discharges by FRGs based on a patient's impairment, age, comorbidities, and functional capability. Initially, there will be 21 rehabilitation impairment categories (RICs) and 92 CMGs. These categories or groups are based on FIM-FRG analysis collected by HCFA and others along with data from the Uniform Data Set.

Like other PPS Medicare programs, the proposed IRF-PPS will have rates that include inpatient operating and capital costs. There will be outliers, deductibles, coinsurance, transfer policies, and wage adjustment factors just as in other programs. Because the BBA required a two-year implementation, IRFs will see reimbursement vary during the implementation period. Implementation will be affected by the IRF's cost-reporting period (on or after April 1, 2001); however, data collection requirements will be required of all facilities no matter what their payment mix. The criteria to be an IRF will not change and acute hospitals with IRF units will see their payment for the IRF unit change accordingly. The only IRFs not affected will be those in VA hospitals, certain demonstration projects, and hospitals that are reimbursed under state cost-control systems approved under 42 CFR part 403.

Security, Privacy, and Electronic Data Interchange

The proposed rule notes that the HIPAA security and privacy rules will affect the encoding of the MDS-PAC data. While this data set transaction set is not currently covered under HIPAA, HCFA has decided to employ these two rules anyway. HCFA also details the accuracy and transmission of the

encoded MDS-PAC data. Unlike HIPAA, HCFA will require testing of the MDS-PAC data and is proposing that such testing take place between February 1-28, 2001. HCFA will be supplying software called MPACT for encoding and transmitting. IRFs can use this software or obtain other software that conforms to the HCFA standard data specifications, data dictionary, and other HCFA-specified data requirements.

Quality Monitoring Strategies

HCFA also goes into detail regarding the framework and specific strategies for quality monitoring in IRFs. Previous concerns regarding IRF quality are noted and HCFA proposes to establish a number of quality indicators. In addition, special interest will be paid to the areas of functional independence and the incidence of pressure ulcers and falls. Finally, HCFA notes that it plans to use the comprehensive quality information derived from MDS-PAC for use in public reporting and to understand which patients fare better in various types of post-acute settings or under what alternatives

The proposed rule is very detailed. Do not assume that this summary or others can take the place of a close review of all the requirements. HCFA has also established a Web site for the IRF-PPS program at www.hcfa.gov/medicare/irfpps.htm. This will be an important site to watch given the short period of time before some of these provisions could become effective. Further, HCFA promises training for providers on the MDS-PAC and the MPACT software. Check with your FI to ensure that you receive this training as soon as possible. Remember, HCFA is proposing testing in February. Given the uncertainty of the times, there could be some significant changes to the content of the November 2000 rule, but be vigilant and don't plan for any delay.

Note

1. The November 3, 2000, Federal Register is available online at http://www.access.gpo.gov/su_docs/fedreg/a001103c.html.

For more on the inpatient rehabilitation PPS, see "Sorting Out the Inpatient Rehabilitation PPS" (Coding Notes, January 2001).

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