LOGIXHealth

Making intelligence matter

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Bundling Together Can Create Meaningful Opportunities

LOGIX TIP#077

In 2015, CMS began bundling ancillary services with an average mean cost of less than $100 into the facility ED/EM level payment.

Call us. Our analytics provide valuable insights into the use of ancillary studies.

2015 OPPS Update

On November 10, 2014, the Centers for Medicare and Medicaid Services published the 2014 Outpatient Prospective Payment System (OPPS) Final Rule in the federal register. The Final Rule finalizes payment rates and policies for outpatient services furnished by hospitals that are paid under the OPPS, and governs services provided on or after January 1, 2015. CMS estimates that total payments (including beneficiary cost sharing) in 2014 to the approximately 4,000 facilities paid under OPPS will be $56.1 billion. This represents an overall increase of $5.1 billion compared to 2014 and a $900 million increase if changes in enrollment, utilization, and case-mix are excluded.

The Facility Conversion Factor

For 2015, the unadjusted conversion factor under OPPS will increase 2.2% from the 2014 value of $72.672 to yield a final 2015 OPPS conversion factor of $74.144. As in prior years, CMS will apply a 2% penalty for hospitals not reporting outpatient quality measures, leading to a final reduced conversion factor of $72.661 for those hospitals not meeting the Hospital Outpatient Quality Reporting (OQR) requirements.

> *"We are continuing to implement the statutory 2.0 percentage point reduction in payments for hospitals failing to meet the hospital outpatient quality reporting requirements, by applying a reporting factor of 0.980 to the OPPS payments and copayments for all applicable services."* OPPS Final Rule page 39/1052

> *"We are using a reduced conversion factor of $72.661 in the calculation of payments for hospitals that fail to meet the Hospital OQR Program requirements (a difference of -$1.483 in the conversion factor relative to hospitals that met the requirements)."* OPPS Final Rule page 231/1052

ED Facility E/M Level Guidelines

CMS still has not developed national ED facility level guidelines, stating:

> *"Since April 7, 2000, we have instructed hospitals to report facility resources for clinic and ED hospital outpatient visits using the CPT E/M codes and to develop internal hospital guidelines for reporting the appropriate visit level (65 FR 18451)."* OPPS Final Rule page 512/1052

Still no national guidelines.

For 2015, there are no significant changes to the rules governing ED facility E/M level guidelines. Per the initial description in the 2008 OPPS Final Rule, hospitals will be allowed to utilize their own scoring systems provided they accurately reflect facility resource utilization and are consistent with the eleven guiding principles published in the 2008 OPPS Final Rule.

> *"Because a national set of hospital-specific codes and guidelines do not currently exist, we have advised hospitals that each hospital's internal guidelines that determine the levels of clinic and ED visits to be reported should follow the intent of the CPT code descriptors, in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the codes."* OPPS Final Rule page 512/1052

CMS determined that it is not currently possible to design a single guideline that would consistently capture the varied patient populations and resources utilized across the nation's emergency departments.

While in past years CMS has been clear in its intent to explore a single set of national ED facility guidelines, the 2015 Final Rule provides insight that CMS is moving away from consideration of a single set of ED guidelines.

"Our work with interested stakeholders, such as hospital associations, along with a contractor, has confirmed that no single approach could consistently and accurately capture hospitals' relative costs. Public comments received on this issue, as well as our own knowledge of how clinics operate, have led us to conclude that it is not feasible to adopt a set of national guidelines for reporting hospital clinic visits that can accommodate the enormous variety of patient populations and service-mix provided by hospitals of all types and sizes throughout the country." OPPS Final Rule page 512/1052

While CMS has moved away from exploration of a single set of uniform national ED coding guidelines, the issue of CMS simply collapsing the five ED facility levels into a single payment APC still exists. In 2014, CMS explored collapsing both ED and outpatient clinic visit levels into corresponding single payment rates. The 2014 Final Rule finalized a collapse of the outpatient clinic levels with a resulting single payment rate under APC 0634; however, the five ED levels remained intact.

"In the CY 2015 proposed OPPS Proposed Rule we stated that we intend to further explore the issues related to ED visits, including concerns about excessively costly patients, such as trauma patients. We also stated that we may propose changes to the coding and APC assignments for ED visits in future rulemaking." OPPS Final Rule page 517/1052

2015 Reporting of All Five ED Levels Continues

The 2015 Final Rule examined the potential collapse of the current five ED facility levels, and concluded the five ED levels will remain for reporting hospital services.

"After consideration of the public comments we received, we are finalizing our proposals, without modification, to continue to use our existing methodology to recognize the existing CPT codes for Type A ED visits as well as the five HCPCS codes that apply to Type B ED visits, and to establish the CY 2015 OPPS payment rates using our established standard process."
OPPS Final Rule page 518/1052

Medicare Payments: ED E/M Levels (Type A)

CPT	APC	2014	2015	Variance
99281	609	$55.65	$60.46	8.7%
99282	613	$100.91	$112.74	11.8%
99283	614	$166.45	$198.31	19.2%
99284	615	$293.71	$333.67	13.6%
99285	616	$455.93	$492.49	8.1%
99291	617	$634.94	$656.69	3.5%

Medicare Payment: ED E/M Levels (Type B)

Type B	APC	2015
Level 1	626	$63
Level 2	627	$69
Level 3	628	$113
Level 4	629	$199
Level 5	630	$304

2015 facility reimbursement to increase from 3.5% to 19.2%.

CMS Facility E/M Level Guiding Principles

- The guidelines should follow the intent of the CPT code descriptor in that the guidelines should be designed to reasonably relate to the intensity of hospital resources to the different levels of effort represented by the code.
- The coding guidelines should be based on hospital facility resources, not physician resources.
- The guidelines should be clear to facilitate accurate payments, and should be usable for compliance purposes and audits.
- They should meet HIPAA guidelines.
- They should only require documentation that is clinically necessary for the patient.
- The guidelines should not facilitate upcoding or gaming.
- These guidelines should be well documented, and should provide the basis for the selection of a specific code.
- They should be applied consistently across patients in the clinic or ED to which they apply.
- These guidelines should not change with great frequency.
- They should be readily available for fiscal intermediary or, if applicable, MAC review.
- These guidelines should result in coding decisions that could be verified by other hospital staff and outside sources.

CCMS -1392-FC pages 872-873

Observation

In 2008, CMS adopted the composite APC methodology, reimbursing for ED and observation services in a single packaged construct. For 2015, the packaged/composite methodology continues to combine ED Facility and observations services into a single APC. In the beginning of 2014, APCs 8002 and 8003 were retired and replaced with a single code (APC 8009). Observation service payments in 2015 will continue to be represented by APC 8009.

The prior reporting constructs continue, and observation services are reported with the G code G0378 (observation services per hour). Payment is made for the composite APC (8009) if the following claim criteria are met:

1. A minimum of 8 units of G0378
2. No procedure with a status indicator of "T" is on the claim for the date of service or one day prior
3. An E/M visit is on the claim, such as:
    a. A Level 4 or 5 Type A ED visit (99284/99285)
    b. Level 5 Type B ED visit
    c. Critical care (99291)
    d. An outpatient clinic visit (G0463)

The reimbursement for the observation composite APC has been steadily increasing over the past several years.

Observation Services

Year	Composite Payment
2009	$660.00
2010	$705.27
2011	$714.33
2012	$720.64
2013	$798.47
2014	$1,199.00
2015	$1,234.22

For 2015, APC 8009 (Extended Assessment & Management Composite — following a high level Type A or B ED visit or critical care) will reimburse $1,234, which represents a 2% increase over the 2014 reimbursement. Of note, due to increased packaging, the baseline 2014 rate of $1,199 represented a 50% increase from 2013.

Packaging of Services

CMS has finalized increased packaging of services in an effort to transform the OPPS into more of a prospective payment system and less like a fee schedule. The 2015 Final Rule describes packaging for services. Items that will be packaged in to the E/M level include:

- Services represented by add-on codes
- Ancillary services with a geometric mean cost of < $100
- Prosthetic supplies

CMS has retired the status indicator X, and has expanded the use of status indicator Q series related to conditional packaging. The status indicator Q series packaging includes:

- Status indicator Q1 - Packaged with status indicator S/T/V procedures
- Status indicator Q2 - Packaged with T procedures
- Status indicator Q3 - Packaged as part of a composite payment

"The final OPPS/ASC rule gives hospitals a stake in managing their resources to generate better coordinated and ultimately more affordable outpatient care."

Dr. Jonathan Blum
Former Deputy Administrator,
Center for Medicaid and
Medicare Services

The OPPS Final Rule lists the various iterations of packaging on a code specific level. For a full copy of the 2015 OPPS Final Rule, visit the LogixHealth website at: www.logixhealth.com.

Importantly, packaging for procedures described by add-on codes was scaled back, and ED Hydration, Injection, and Infusion services will continue to be reported and paid separately.

CMS published the below table related to the packaging of services related to geometric mean cost < $100.

"The APCs that we are conditionally packaging as ancillary services in CY 2015 are listed in Table 12 below." OPPS Final Rule page 216/1052

Most lab tests, including typical ED testing, most plain x-rays, and certain minor ED procedures (such as simple lacerations) will be packaged in 2015.

APCs for Conditionally Packaged Ancillary Services for CT 2015

APC	Proposed CY 2015 Geometric Mean Cost	CY 2015 OPPS Geometric Mean Cost (with application of Q1 Status Indicator)	Group Title
0012	$76.29	$102.18	Level I Debridement & Destruction
0060	$20.64	$20.57	Manipulation Therapy
0077	$52.08	$170.77	Level I Pulmonary Treatment
0099	$81.27	$81.40	Electrocardiograms/Cardiography
0215	$104.63	$98.52	Level I Nerve and Muscle Services
0230	$55.00	$54.01	Level I Eye Tests & Treatments
0260	$62.43	$61.59	Level I Plain Film Including Bone Density Measurement
0261	$99.85	$98.56	Level II Plain Film Including Bone Density Measurement
0265	$96.51	$95.12	Level I Diagnostic and Screening Ultrasound
0340	$64.78	$54.33	Level II Minor Procedures
0342	$56.99	$56.31	Level I Pathology
0345	$78.83	$78.91	Level I Transfusion Laboratory Procedures
0364	$42.69	$44.94	Level I Audiometry
0365	$123.21	$122.36	Level II Audiometry
0367	$166.31	$167.31	Level I Pulmonary Tests
0420	$130.93	$136.66	Level III Minor Procedures
0433	$190.21	$190.55	Level II Pathology
0450	$29.91	$30.33	Level I Minor Procedures
0624	$83.61	$81.76	Phlebotomy and Minor Vascular Access Device Procedures
0690	$37.25	$36.47	Level I Electronic Analysis of Devices
0698	$106.17	$104.61	Level II Eye Tests and Treatments

Table 12 OPPS Final Rule page 216/1052

Critical Care

In 2011, CPT updated language within the definition of 99291, allowing facilities to report some services, such as x-rays, gastric intubation, and transcutaneous pacing that are bundled under Physician Payment Rules. Despite this change, for 2012-2014, and now 2015, there will not be any separate OPPS payment made outside of the APC for these additional services. Critical care will continue to be reported by facilities with code 99291, which crosswalks to APC 617 and, for 2015, reimburses $656.69.

"We are finalizing our proposals, without modification, to continue our policy to recognize the existing CPT codes for critical care services and establish a payment rate based on historical claims data, and to continue to implement claims processing edits that conditionally package payment for the ancillary services that are reported on the same date of service as critical care services in order to avoid overpayment." OPPS Final Rule page 520/1052

Hydration/Injection/Infusion Update

Each year, the OPPS Final Rule updates reimbursement rates for essential ED services. In particular, with the complex coding rules surrounding the high frequency Hydration, Injection, and Infusion codes, there is significant revenue at stake for these procedures.

Big dollars are at stake for correct coding of infusion services.

CPT Code	Description	2015 Payment
96360	Hydration IV infusion, initial	$108.20
96361	Hydration IV infusion, add-on	$32.57
96365	Therapeutic/prophylactic/diagnostic IV infusion, initial	$173.53
96366	Therapeutic/prophylactic/diagnostic IV infusion, add-on	$32.57
96367	Therapeutic/prophylactic/diagnostic additional sequential IV infusion	$53.52
96372	Therapeutic/prophylactic/diagnostic injection, SC/IM	$53.52
96374	Therapeutic/prophylactic/diagnostic injection, IV push	$108.20
96375	Therapeutic/prophylactic/diagnostic injection new drug add-on	$32.57

Hospital Outpatient Quality Reporting

CMS has made clear its commitment to expanding quality tracking. Hospitals failing to report quality measures will suffer a 2% reduction in their conversion factor. Each year, CMS issues an expanded list of hospital measures required for meeting reporting requirements. Additionally, as the administrative and clinical realities of the quality measures become realized, some measures are subsequently postponed or suspended.

The 2015 OPPS Final Rule finalizes one new measure for the OQR program, affecting the CY 2018 payment determination and subsequent years.

OP- 32 Facility Seven-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy

The Final Rule also removes several measures for the CY 2017 payment determination and subsequent year, including several that are particularly relevant to the ED shown in the table on the following page: from the OPPS Final Rule page 692/1052.

Hospital OQR Program Measures Removed for the CY 2017 Payment Determination and Subsequent Years

NQF#	Measure
N/A	OP-6: Timing of prophylaxis antibiotic
0528	OP-7: Prophylactic antibiotic selection for surgical patients

The OQR measure set determining payment for CY 2016 is shown below:

Hospital OQR Measure Set CY 2016 Payment Determination	
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
OP-14	Simultaneous use of brain computed tomography (CT) and sinus computed tomography (CT)
OP-15	Use of brain (CT) in the emergency department for atraumatic headache (postponed)
OP-17	Tracking clinical results between visits
OP-18	Median time from ED arrival to ED departure for 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 before being seen
OP-23	ED – head CT scan results for acute ischemic stroke or hemorrhagic stroke patients within 45 minutes of arrival
OP-25	Safe surgery checklist
OP-26	Hospital outpatient volume on selected outpatient procedures
OP-27	Influenza vaccination coverage among healthcare personnel
OP-29	Endoscopy/polyp surveillance: appropriate follow-up interval for normal colonoscopy in average risk patients
OP-30	Endoscopy/polyp surveillance: colonoscopy Interval for patients with a history of adenomatous polyps – avoidance of inappropriate use
OP-31	Cataracts – improvement in patient's visual function within 90 days following cataract surgery

Hospital Value-Based Purchasing Program

CMS continues to provide further detail relating to the vision for expansion of the Hospital Value Based Purchasing Program (HVBP). The HVBP will be funded by a 1.50% reduction from participating hospitals' base operating diagnosis-related group (DRG) payments for FY 2015, which will be increasing to 2% by 2017. Hospitals then earn back a portion of the withhold based on relative scoring for both CORE measures and the CMS HCAHPS satisfaction survey.

Hospital Readmission Reduction Program

The maximum reduction in payments under the Hospital Readmissions Reduction Program will increase from 2% to 3% as required by law. For FY 2015, CMS will assess hospitals' readmissions penalties using five readmissions measures:

- Heart attack
- Heart failure
- Pneumonia
- Chronic obstructive pulmonary disease
- Hip/knee arthroplasty

Hospital Acquired Condition Reduction Program

CMS is implementing the Affordable Care Act's Hospital Acquired Condition Reduction Program. Beginning in FY 2015, hospitals scoring in the top quartile for the rate of HACs (i.e. those with the poorest performance) will have their Medicare inpatient payments reduced by 1%.

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