

# CMS proposes two significant changes for OPPS 2013

Written by By Michelle Leppert, CPC-A, HCPro

CMS is proposing two major changes as part of the [2013 Outpatient Prospective Payment System \(OPPS\) proposed rule](#), released July 6. One has to do with how CMS proposes to calculate APC relative weights and the other with the reimbursement level for separately payable drugs and biologicals without pass-through status.

The 2013 proposed rule is approximately half the size of the 2012 proposed rule and does not contain as many changes. However, the proposed suggestions are significant because they represent a major difference in how CMS has been making payments, says **Jugna Shah, MPH**, president of Nimit Consulting in Washington, DC.

## Relative weight calculation

CMS proposes to change the way it calculates APC relative weights. Since the beginning of OPSS, CMS has used median cost data that it derives from provider claims to calculate relative weights that are used to pay for the vast majority of OPSS/APC services. For calendar year 2013, CMS suggests using the geometric mean cost to create APC relative weights.

In the proposed rule, CMS states that it is proposing to shift the basis for the CY 2013 APC relative weights that underpin the OPSS from median costs to geometric mean costs. CMS cites several reasons, including that the use of the geometric mean would better capture the range of costs associated with providing services, including those cases involving high-cost packaged items or services, and those cases where very efficient hospitals have provided services at much lower costs. The use of geometric mean costs also would allow CMS to detect changes in the cost of services earlier.

In addition, CMS states, "this proposed change would bring the OPSS in line with the IPPS [Inpatient Prospective Payment System], which utilizes hospital costs derived from claims and cost report data to calculate prospective payments, and specifically, mean costs rather than median costs to form the basis of the relative payment weights associated with each of the payment classification groups."

Shah was surprised to see this proposal from CMS as she says the agency has relied upon median cost data from the beginning of OPSS, adding that the proposal is interesting and requires further review and analysis.

CMS released online a file called the 2013 Geometric Mean Median Change, which is a great way to begin reviewing the payment change/impact of CMS' proposal at the CPT® and APC level, Shah says. The file is basically a different view of Addendum B, where CMS shows what payments would be under the proposed geometric mean approach compared to the continued use of median cost data.

Some APC payments go up, while others go down and a few of the changes are significant. For example, use of the geometric mean cost vs. median cost results in the APC payment for the level I Type B ED visit to increase by 42.5%, says Shah. Looking at the E/M visit codes in general for the clinic and ED setting results in payment rate changes in both directions, while a similar review of the intravenous injection and infusion drug administration codes shows that most of these APC payment rates increase under the geometric mean methodology, Shah says.

However, other APC payments drop significantly. For example, the proposed APC payment rates for CPT codes assigned to APC 139 could decrease by 31.4%, Shah says. A detailed review of CMS' proposal is required and as always providers should provide comments to CMS.

## **Separately payable drugs**

For CY 2013, CMS proposes to reimburse hospitals for separately payable drugs and biologicals without pass-through status at average sales price (ASP) plus 6%, a 2% increase from 2012.

"I am very excited about this," Shah says. "We have been trying to get CMS to make this change for years, and now the agency has finally included this in its proposed rule." CMS' proposal for 2013 would finally result in payment parity for separately payable drugs in the physician office setting, which is something that providers have been pushing the agency to do. CMS is able to provide payment at the level of ASP +6% by statute if it believes that it does not have average acquisition cost data for separately payable drugs, and though the agency hasn't relied on this argument or the statute in the past, it appears to be doing so for 2013.

While hospitals are likely to be pleased with CMS' proposal of ASP+6%, it is unlikely that most will agree that this payment level is sufficient to cover both drug acquisition costs and pharmacy handling costs, says Shah. "It will be interesting to see what sorts of comments CMS receives on its proposal."

CMS proposed no changes to evaluation and management codes or guidelines and reiterated that new and established designations for patients remain in effect. In addition, CMS did not propose any additional composite APCs nor did it propose any changes related to drug administration. Despite no policy changes, payment rates do shift and hospitals should take note of these payment impacts, says Shah. Finally, CMS says it has not proposed any new quality measures for 2014 or 2015 payment determinations.

## **Continuing adjustments, enforcement delays**

CMS plan to continue the 7.1% OPPS payment adjustment to certain rural sole community hospitals (SCHs), including essential access community hospitals (EACHs). This adjustment would apply to all services paid under the OPPS, excluding separately payable drugs and biologicals, devices paid under the pass-through payment policy, and items paid at charges reduced to cost.

CMS also plans to continue providing additional payments to cancer hospitals so that the hospital's payment-to-cost ratio (PCR) with the payment adjustment is equal to the weighted average PCR for the other OPPS hospitals using the most recent submitted or settled cost report data.

For CY 2013, CMS proposes to make an additional payment of \$10, to cover the marginal costs associated with non-highly enriched uranium (HEU) Tc-99m production. CMS suggests establishing a new HCPCS code, QXXXX (Tc-99m from non-HEU source, full cost recovery add-on, per dose) to describe the Tc-99m radioisotope produced by non-HEU methods and used in a diagnostic procedure.

Hospitals would report this code once per dose along with any diagnostic scan or scans using Tc-99m as long as the Tc-99m doses used can be certified by the hospital as coming from non-HEU. The code would pay hospitals for the additional (marginal) cost of using Tc-99m from a non-HEU source.

What's nice about this proposal is that CMS recognizes that it would be inappropriate to ask hospitals to absorb the marginal cost for radioisotopes produced from non-HEU sources over the costs for radioisotopes produced by HEU sources, Shah says. The CMS suggestion provides an extra payment to ensure that hospitals receive appropriate payments in light of the government's agenda to change its HEU policy, she says.

CMS also proposed extending another year the delay on enforcement of physician supervision rules for critical access hospitals (CAH) as well as small and rural hospitals with 100 or fewer beds.

The proposed rule will appear in the July 30 Federal Register. CMS will accept comments on the proposed rule until September 4, and will respond to all comments in a final rule to be issued by November 1. As always, Shah stresses the importance of hospital involvement and urges organizations to provide comments and feedback to CMS.