

MLN Matters Number: MM6072

Related Change Request (CR) #: 6072

Related CR Release Date: August 15, 2008

Effective Date: January 1, 2009

Related CR Transmittal #: R368OTN

Implementation Date: January 5, 2009

Application of the Hospital Outpatient Quality Data Reporting Program under the Hospital Outpatient Prospective Payment System (OPPS)

Note: This article was revised on January 2, 2009, to reflect that CR6320 made a correction to CR6072, on which this article is based. The correction to CR6072 was to include blood APCs with status indicator “R” under the application of the quality reporting ratio where appropriate. This addition of status indicator “R” was made to the bold printed language in the first full paragraph on page 3 of this article. All other information remains the same.

Provider Types Affected

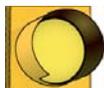
This article is intended for hospitals submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed



STOP – Impact to You

This article is based on Change Request (CR) 6072 regarding application of the Hospital Outpatient Quality Data Reporting Program to services paid under the Hospital OPPS, effective for services rendered on or after January 1, 2009.



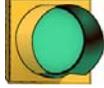
CAUTION – What You Need to Know

Effective for OPPS services furnished on or after January 1, 2009, ‘subsection (d) hospitals’ that have failed to submit timely outpatient hospital quality data as required in the Social Security Act (Section 1833(t)(17)(A)) will receive payment under the OPPS that reflects **a two percent deduction from the annual OPPS update** for failure to submit quality data in a timely manner

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or for failure to submit quality data that passes validation edits. Hospitals that are not required to submit quality data (i.e. that are not ‘subsection (d) hospitals’) will receive the full update. Similarly, the reduction will not apply to subpart (d) hospitals that are not paid under the OPSS (for example, Indian Health service hospitals).



GO – What You Need to Do

See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

As a condition for receiving the full market basket update on their Inpatient Prospective Payment System (IPPS) payments, all hospitals defined as ‘subsection (d) hospitals’, are required to report hospital quality data:

- In a timely manner, and
- In a way that passes the Centers for Medicare & Medicaid Services (CMS) validation edits for inpatients receiving services in the hospital.

Effective for services furnished on or after January 1, 2009, this policy will also apply to services paid under OPSS to ‘subsection (d) hospitals’.

‘Subsection (d) hospitals’ have the same definition for hospitals paid under the OPSS as for hospitals paid under the IPPS. Specifically, ‘subsection (d) hospitals’ are defined in the Social Security Act (Section 1886(d)(1)(B); http://www.ssa.gov/OP_Home/ssact/title18/1886.htm on the Internet) as hospitals that are located in the fifty states or the District of Columbia other than those categories of hospitals or hospital units that are specifically excluded from the IPPS, including psychiatric, rehabilitation, long-term care, children’s and cancer hospitals or hospital units. In other words, the provision does not apply to hospitals and hospital units excluded from the IPPS, or to hospitals located in Maryland, Puerto Rico, or the U.S. territories.

CR 6072 announces that, effective for OPSS services furnished on or after January 1, 2009, **‘subsection (d) hospitals’ that have failed to submit timely outpatient hospital quality data as required in the Social Security Act (Section 1833(t)(17)(A); http://www.ssa.gov/OP_Home/ssact/title18/1833.htm on the Internet) will receive payment under the OPSS that reflects a two percent deduction from the annual OPSS update for failure to submit quality data in a timely manner or for failure to submit quality data that passes validation edit. Where hospitals are required to report the quality data and fail to do so, the OPSS Pricer will assign a new return code of 11 (Reduced for absent quality reporting) when a payment APC on a line has a status indicator equal to P, R, or S (if APC is not 1491-1537), T (if APC is not 1539-1574), V, or X.**

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Hospitals that are not required to submit quality data (that is, that are not ‘subsection (d) hospitals’) will receive the full update. Similarly, the reduction will not apply to subpart (d) hospitals that are not paid under the OPPS (for example, Indian Health service hospitals).

CMS will send your FI or MAC a file of hospitals to which the reduction will apply as soon as the list is available. This is expected to be on or about December 1 of each year. Should a ‘Subsection (d) hospital’ later be determined to have met the criteria after publication of this list, their status will be changed and FIs/MACs will be notified.

For new hospitals, FIs/MACs will provide information to CMS (or a CMS-designated contractor) to allow contact with the new facilities to inform them of the Hospital Quality Initiative.

Additional Information

The official instruction, CR 6072, issued to your FI and A/B MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R368OTN.pdf>.

If you have any questions, please contact your FI or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html>.

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