

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 368	Date: August 15, 2008
	Change Request 6072

NOTE: This Transmittal is no longer sensitive and is being re-communicated November 3, 2008. This instruction is being resent because of the release of the CY 2009 OPPS Final Rule. The Transmittal Number, date of Transmittal and all other information remain the same.

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

I. SUMMARY OF CHANGES: 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 section 1833(t)(17)(A) of the Act 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 or for failure to submit quality data that passes validation edit. 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 OPPS (e.g. Indian Health service hospitals).

New / Revised Material

Effective Date: January 1, 2009

Implementation Date: January 5, 2009

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

R/N/D	Chapter / Section / Subsection / Title
N/A	N/A

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One-Time Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment - One-Time Notification

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

Effective Date: January 1, 2009

Implementation Date: January 5, 2009

I. GENERAL INFORMATION

A. Background: Hospitals that meet the definition of “Subsection (d) hospitals” are required to report hospital quality data in a timely manner and in a manner that passes CMS validation edits for inpatients receiving services in the hospital as a condition of receiving the full market basket update on their Inpatient Prospective Payment System (IPPS) payments. Effective for services furnished on or after January 1, 2009, this policy will also apply for 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 under Section 1886(d)(1)(B) of the Act as hospitals that are located in the 50 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.

B. Policy: 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 Section 1833(t)(17)(A) of the Act will receive payment under the OPSS that reflects a 2 percentage point 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. Hospitals that are not required to submit quality data (i.e., those 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 (e.g., Indian Health service hospitals).

The FISS shall auto populate the field with a “1” for all hospitals. Once CMS has issued the list of hospitals failing to meet the criteria, Fiscal intermediaries (FIs)/Medicare Administrative Contractors (MACs) shall remove the ‘1’ in the Hospital Quality Indicator field for each Subsection (d) hospital that fails to meet the reporting criteria, making no change for any hospital that is not a Subsection (d) hospital providing OPSS services.

CMS will send FI/MACs the file of hospitals to which the reduction will apply by a Joint Signature Memorandum/Technical Direction Letter 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 and must update the OPSF as needed and mass adjust paid claims.

For new hospitals, FIs/MACs shall provide information to the Quality Contractor to be specified by CMS as soon as possible so that the Quality Contractor can enter the provider information into the Program Resource System and follow through with ensuring provider participation with the requirements for quality data reporting, if applicable. This allows the contractor the opportunity to contact new facilities earlier in the FY to inform them of the Hospital Quality Initiative.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D E M A C	F I M A C	C A R E R	R H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
6072.1	FISS shall accommodate a new Hospital Quality Indicator field in the Outpatient Provider Specific File (OPSF).						X				
6072.1.1	FISS shall split the existing 2-byte Filler field in the OPSF into 2 fields: a 1-byte Hospital Quality Indicator field; and a 1-byte Filler field (both bytes will remain alpha-numeric).						X				
6072.2	<p>FIs/MACs shall correctly code the Hospital Quality Indicator field in the OPSF to indicate that the hospital meets data submission criteria per MMA quality standards.</p> <p>Below are the following values for Hospital Quality Indicator field:</p> <p>Blank = Hospital does not meet criteria 1 = Hospital quality reporting standards have been met or hospital is not required to submit quality data (e.g. hospitals that are specifically excluded from the IPPS or which are not paid under the OPPS, including psychiatric, rehabilitation, long-term care, children's,</p>	X		X							

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I M A C	C A R E R	R H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
	and cancer hospitals, Maryland hospitals, Indian Health Service hospitals, or hospital units; or hospitals that are located in Puerto Rico or the U.S. territories). The reduction does not apply to hospices, CORFs, HHAs, CMHCs, critical access hospitals or to any other provider type that is not a hospital. See attached lay-up table area for the provider specific record.										
6072.2.1	FISS shall annually auto-populate the Quality Indicator Fields in the OPSF with the value of "1" with an effective date of the January 1 of the applicable year (e.g. January 1, 2009 for the CY 2009 OPSS). For CY 2009 OPSS, this requirement shall be completed no later than January 5, 2009.						X				
6072.2.2	To determine which hospitals do not meet the data criteria, FIs/MACs shall refer to the file of hospitals that fail the criteria that will be furnished by CMS via a Joint Signature Memorandum/Technical Direction Letter.	X		X							
6072.2.3	FIs/MACs shall ensure that the OPSF Hospital Quality Indicator is updated annually with an effective date of the January 1 of the applicable year (e.g. January 1, 2009 for the CY 2009 OPSS).	X		X			X				
6072.2.4	FIs/MACs shall update the OPSF as early as possible, but no later than January 12, 2009, so clean claims are not delayed.	X		X							
6072.2.5	FIs/MACs shall change the OPSF Hospital Quality Indicator within 7 days of receipt of the annual update file or a file of changes to the annual update file from CMS.	X		X							
6072.2.6	FISS shall add the new OPSF field to ECPS to provide the capability of creating ECPS events for adjustments due to quality.						X				
6072.2.6.1	FIs/MACs shall adjust any OPSS claims with dates of service on or after January 1, 2009, that had an	X		X			X				all data centers

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I M A C	C A R R I E R	R H I I S S	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
	incorrect quality indicator prior to processing, or a quality indicator that was retroactively changed.										
6072.2.7	FISS shall provide FI/MACs with the capability to capture claims that processed with the incorrect OPSF indicator, read the provider file and mass adjust the claims.						X				
6072.3	OPPS Pricer shall reduce the APC payment by applying the reduced update ratio applicable to the date of service if the quality reporting field in the OPSF is blank and the payment APC on the line has a status indicator equal to any of the following: P, S if APC is not 1491-1537, T if APC is not 1539-1574, V, X.										OPPS Pricer
6072.3.1	OPPS Pricer shall assign new return code 11, "Reduced for absent quality reporting", if the quality reporting field in the OPSF is blank and the payment APC on the line has a status indicator equal to any of the following: P, , S if APC is not 1491-1537, T if APC is not 1539-1574, V, X.						X				OPPS Pricer
6072.4	OPPS Pricer shall apply the reduced update ratio to the full update coinsurance if the quality reporting field in the OPSF is blank and the payment APC on the line has a status indicator equal to any of the following: P, S if APC is not 1491-1537, T if APC is not 1539-1574, V, X.										OPPS Pricer
6072.5	OPPS Pricer shall use the reduced payment when applicable (following application of the reduced update ratio) in the calculation of outlier payments in cases in which the quality reporting field in the OPSF is blank and the payment APC on the line has a status indicator equal to any of the following: P, S if APC is not 1491-1537, T if APC is not 1539-1574, V, X.										OPPS Pricer
6072.6	FIs/MACs shall provide the following information on newly participating hospitals to the Quality Contractor to be specified by CMS as soon as possible: State code Provider name Provider ID number Medicare accept date	X		X							

Number	Requirement	Responsibility (place an "X" in each applicable column)								
		A / B	D M E	F I	C A R R I E R	R H I	Shared-System Maintainers			
		M A C	M A C			I S S	M S	V M S	C W F	
	Contact name (if available) Telephone number									

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)								
		A / B	D M E	F I	C A R R I E R	R H I	Shared-System Maintainers			
		M A C	M A C			I S S	M S	V M S	C W F	
6072.7	Medicare contractors shall not begin provider education until they receive notification from CMS that this information can be shared with providers	X		X						
6072.8	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X						

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s):

Quality Reporting Issues: Sheila Blackstock at 410-786-3502

Payment Policy: Anita Heygster at 410-786-4486

Claims Processing: Joseph Bryson at 410-786-2986 or Maria Durham at 410-786-6978

Post-Implementation Contact(s):

Regional Office

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Intermediaries (RHHIs)*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: For *Medicare Administrative Contractors (MACs)*:

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ATTACHMENT: Layout Table Area for Provider Specific Record

Attachment

The following is the OCE linkage section for the January 2009 OPPS PRICER:

* LAYUP TABLE AREA FOR PROVIDER SPECIFIC RECORD *

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01 L-PROV-SPEC-AREA.
    05 L-PSF-NPI PIC X(08).
    05 L-PSF-NPI-FILLER PIC X(02).
    05 L-PSF-PROV-OSCAR.
        10 L-PSF-PROV-ST PIC X(02).
        10 L-PSF-PROV-3456 PIC X(04).
    05 L-PSF-EFFDT PIC 9(08).
    05 L-PSF-FY-BEGIN-DT PIC 9(08).
    05 L-PSF-REPORT-DT PIC 9(08).
    05 L-PSF-TERMDT PIC 9(08).
    05 L-PSF-WAIVE-IND PIC X(01).
    05 L-PSF-FI-NUM PIC 9(05).
    05 L-PSF-PROV-TYPE PIC X(02).
    05 L-PSF-SPCL-LOCATION-IND PIC X(01).
    05 L-PSF-WGIDX-RECLASS PIC X(01).
    05 L-PSF-GEO-MSA PIC X(04).
    05 L-PSF-WI-MSA PIC X(04).
    05 L-PSF-COLA PIC 9V9(03).
    05 L-PSF-STATE-CODE PIC 9(02).
    05 L-PSF-TOPS-INDICATOR PIC X(01).
    05 L-PSF-HOSP-QUAL-IND PIC X(01).
    05 FILLER PIC X(01).
    05 L-PSF-OPCOST-RATIO PIC 9V9(03).
    05 L-PSF-GEO-CBSA PIC X(05).
    05 L-PSF-WI-CBSA PIC X(05).
    05 L-PSF-SPEC-WGIDX PIC 9(02)V9(04).
    05 L-PSF-SPEC-PYMT-IND PIC X(01).
    05 L-PSF-APC-LINE-CNT PIC 9(04).
    05 L-PSF-APC-TABLE OCCURS 999 TIMES
        DEPENDING ON L-PSF-APC-LINE-CNT.
        10 L-PSF-APC PIC X(04).
        10 L-PSF-RED-COIN PIC 9(04)V99.
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