

## **Medicare 2004 OPPS Final Rule Claims Accounting**

Good news!! CMS used information from over 44.7 million claims to set the APC rates for services paid under Medicare OPPS for 2004 and used 7.7 million claims to set the APC rates for drugs and biologicals paid under OPPS for 2004. CMS continues to seek ways to use as many of the claims for services paid under OPPS as possible.

Attached is a narrative description of the accounting of claims used in the setting of payment rates for Medicare's 2004 Outpatient Prospective Payment System (OPPS). Payment rates under OPPS are based on the median cost of all services (i.e. HCPCS codes) in an APC. As described in detail in the material that follows, median costs were calculated from claims for services paid under the Medicare OPPS and cost report data for the hospitals whose claims were used. The medians were converted to payment weights by dividing the median for each APC (a group of HCPCS codes) by the median cost for APC 601, a mid level outpatient visit. The resulting unscaled weights were scaled for budget neutrality to ensure that the total amount of weight in the system was no greater for 2004 than it was for 2003. The scaled weights were multiplied by the 2004 conversion factor to set the national unadjusted payment rate for the APCs for 2004. Further discussion of the setting of the payment rates for 2004 OPPS is contained in the Friday November 7 Federal Register at 68FR63398.

The purpose of this claims accounting is to help the public understand the order in which CMS processed claims to produce the 2004 OPPS APC median costs, the proportion of claims that CMS used to set the OPPS payment rates and the reason that not all claims could be used.

## **General Information:**

In order to calculate the median APC costs that form the basis of OPPS payment rates, CMS must isolate the specific resources associated with each unique payable procedure (which has a HCPCS code) in each APC. Much of the following description, Pre-stage 1 through Stage 3, covers the activity by which CMS 1) extracts the direct charge (i.e. a charge on a line with a separately paid HCPCS code) and the supporting charge (i.e. a charge on a line with a packaged HCPCS or packaged revenue code) for a single, major payable procedure for one unit of the procedure and 2) packages the supporting charges with the charges for the single unit of the major procedure to acquire a full cost for the single unit of the major procedure. CMS estimates resource costs from the billed charges by applying a cost to charge ratio from the hospital's most recent settled cost report to adjust the charges to cost. Wherever possible, departmental cost to charge ratios are applied to charges with related revenue codes (e.g. pharmacy CCR applied to charges with a pharmacy revenue code). In general, CMS carries the following data elements from the claim through the weight setting process: revenue code, date of service, HCPCS code, charges (for all lines with a HCPCS code or if there is no HCPCS code, with an allowed revenue code), and units. Some specific median calculations may require more data elements.

## **Definitions of terms used:**

“Excluded” means the claims were eliminated from further use.

“Removed to another file” means that we removed them from the general process but put them on another file to be used in a different process; they did not remain in the main run but were not eliminated because the claims were used to set medians for a specific purpose.

“Copy to another file” means that we copied information off the claims but did not exclude any of the information copied off.

“STAGE” means a set of activities that are done in the same run or a series of related runs; the STAGE numbers follow the stages identified in a spreadsheet that accounts for the claims.

“\*” Indicates a component of the limited data set and beneficiary encrypted data set (the public use files available for purchase from CMS).

## **Pre-STAGE 1: Identified gross outpatient claim population used for OPPS payment and applied the hospital cost-to-charge ratios.**

Pulled claims for calendar year 2002 from the national claims history, n=27,151,590 records with a total claim count of 126,666,312. This is not the

population of claims paid under OPPS, but all outpatient claims processed by fiscal intermediaries.

Excluded claims with condition code 04, 20, 21, 77 (n=431,531). These are claims that providers submitted to Medicare knowing that no payment will be made. For example, providers submit claims with a condition code 21 to elicit an official denial notice from Medicare and document that a service is not covered.

Excluded claims for services furnished in Maryland, Guam and the US Virgin Islands, n=1,671,459.

**Balance = 124,563,322**

Divided claims into three groups:

- 1) Claims that were not bill type 12X, 13X, 14X (hospital bill types) or 76X (CMHC bill types). Other bill types, such as ASCs, are not paid under OPPS and, therefore, these claims were not used to set OPPS payment. (n=21,912,380)
- 2) Bill types 12X, 13X, or 14X (hospital bill types). These claims are hospital outpatient claims. (n=102,589,349)
- 3) Bill type 76X (CMHC) (These claims are later combined with any claims in 2 above with a condition code 41 to set the per diem partial hospitalization rate through a separate process.) (n=61,593)

Exclude claims with a claim “from date” on or before March 31, 2002. For the 2004 rule, CMS decided not to use the first quarter of claims for 2002 because these claims had also been used to set payment for 2003. This edit excluded 24,737,660 claims from bill types 12X, 13X, and 14X and 13,246 claims from bill types 76X. This edit will not be used for the 2005 rule. CMS is using a full calendar year of claims.

**Balance for Bill Types 12X, 13X, and 14X = 77,851,689**

Applied hospital cost-to-charge ratios (CCRs) to claims and flagged hospitals with CCRs that will be excluded in Stage 1 below.

**STAGE 1: Further refined the population of claims to those with a valid cost-to-charge ratio and removed claims for those procedures with idiosyncratic packaging and median calculation processes to separate files.**

Began with the set of claims with bill types 12X, 13X, or 14X with correct service dates, without MD, Guam or USVI, and with flags for invalid CCRs set, n=77,851,689

Excluded claims with CCRs that were flagged as invalid in Pre -Stage 1. These included claims for hospitals without a CCR, for hospitals paid an all inclusive rate, for critical access hospitals, for hospitals with obviously erroneous CCRs (greater than 90 or less than .0001), and for hospitals with CCRs that were identified as outliers (3 standard deviations from the geometric mean after removing error CCRs), n=3,112,526.

**Balance = 74,739,163**

Identified claims with condition code 41 and removed to another file, n=34,280. These claims were combined with the 48,347 76X claims identified in Pre-Stage 1 to calculate the partial hospitalization per diem rate.

**Balance = 74,704,883**

Excluded claims without a HCPCS code = 18,409.

**Balance = 74,686,474**

\*Removed to another file, claims for observation = 30,092.

**Balance = 74,656,382**

Removed to another file claims that contain nothing but flu and PPV vaccine = 387,981.

**Balance = 74,268,401.**

Copied line items for drugs, blood, and devices (the lines stay on the claim but are copied off onto another file) to a separate file. No claims were deleted. Lines copied, n=7,708,633. These line-items are used to calculate a per unit median for drugs, blood, and devices, such as brachytherapy seeds.

**STAGE 2 Excluded claims with codes not payable under OPPS, conducted initial split of claims into single and multiple bills, and prepared claims for pseudo single claim creation.**

Divided claims into 5 groups.

- 1) **\*Single Major File:** Claims with a single unit of one separately payable procedure (which is called a “major” procedure), all of which will be used in median setting, n=24,059,462
- 2) **\*Multiple Major File:** Claims with more than one separately payable procedure and/or multiple units of “major” procedures, n=16,324,562. (These are examined carefully for dates of service and content to see if they can be divided into pseudo single claims.)
- 3) **\*Single Minor File:** Claims with a single HCPCS that is not separately payable (which is called a “minor” procedure), n=366,021 (These claims may have a single packaged procedure or a drug code. We retain this file as insurance against last minute changes in packaging decisions.
- 4) **\*Multiple Minor File:** Claims with multiple HCPCS, multiple services on the same date of service, and/or that have multiple units that are not separately payable without examining dates of service, n=537,301. (For example, pathologies are packaged unless they appear on a single bill by themselves. The multiple minor file has claims with multiple occurrences of pathology codes, with packaged costs that cannot be appropriately allocated across the multiple pathologies. However, in examining dates of service under Stage 3 below, a claim with multiple pathologies may become several pseudo single claims with a unique pathology on each day. These pseudo singles for the pathology codes would then be considered a separately payable.)
- 5) **Non-OPPS claims** These claims have no services payable under OPPS on the claim and are excluded, n=32,981,055 These claims have codes paid under other fee schedules such as the DMEPOS fee schedule, clinical laboratory fee schedule, physician fee schedule.

We excluded claims in files 3) and 5) above.

**Balance = 40,921,325 (This is the sum of claims in files 1, 2 and 4 above)**

### **STAGE 3 Created pseudo singles from multiple claims**

From the 16,324,562 multiple major claims, we were able to use 9,593,098 to create 27,059,784 pseudo single claims. Pseudo singles are the result of grouping procedures on a claim by date of service and by using a list of bypass codes to remove separately payable procedures that are thought to contain limited packaging from a multiple bill. We were not able to use 6,731,464 claims because these claims continued to contain multiple separately payable procedures among which packaged costs could not be accurately allocated. These claims were excluded.

From the 537,301 multiple minor claims, we were able to use 240,604 multiple minor claims to create 613,940 pseudo single claims. We were not able to use 296,697 multiple minor claims for the same reasons discussed above, and they were excluded.

**Balance = 51,733,186** (the sum of single majors = 24,059,462, pseudo singles from multiple majors = 27,059,784, and pseudo singles from multiple minors = 613,940)

### **STAGE 3A Special treatment of selected device-insertion APCs – a parallel median calculation that occurs while Stages 4 and 5 proceed.**

From the claims surviving stage 3 above, copied off claims containing codes in specified APCs for inserting devices, n=253,596. Examples of these APCs include 0032, 0048, and 0080.

Excluded any claims that do not contain a packaged device code on the claim, n=132,126. Some of the claims with a HCPCS for device insertion either did not have a code and charges for the packaged device, or there were uncoded charges appearing in device revenue centers that were much lower than the anticipated cost of the device.

**Balance = 121,470**

Excluded any claims that do not contain the selected C codes for selected APCs = 2,290

**Balance = 119,180**

Packaged and calculated medians, as described in Stages 4 and 5, for these claims to create medians for the selected device-insertion APCs.

### **STAGE 4 Packaged costs into the payable HCPCS code**

Began with, n=51,733,186, claims that still had costs at the line-item level.

Completed packaging and left stage 4 with n=51,733,186 claims containing summarized costs for the payable HCPCS and all packaged codes and revenue centers on the claim.

**Balance= 51,733,186**

### **STAGE 5 Calculated HCPCS and APC medians**

Began with n=51,733,186 claims with summarized costs.

Excluded 6,591,647 claims that either had zero costs after summing all costs on the claim in Stage 4 or for which CMS lacked an appropriate wage index.

Excluded 414,703 claims that were outside +/- 3 standard deviations from the geometric mean cost for each HCPCS code.

**Balance=44,726,836**

We used the balance of 44,726,836 claims to calculate HCPCS median costs (for the “2 times” examination and APC medians. (Section 1833(t)(2) of the Act provides that, subject to certain exceptions, the items and services within an APC group cannot be considered comparable with respect to the use of resources if the highest median (or mean cost, if elected by the Secretary) for an item or service in the group is more than 2 times greater than the lowest median cost for an item or service within the same group (referred to as the “2 times rule”).)

Medians for selected device-insertion APCs were replaced with medians calculated in Stage 3A.

Added a median for observation, which was calculated from the 30,092 claims written off in Stage 1 through a separate process.

Added a median per diem cost for partial hospitalization. The per diem cost was calculated from the 34,280 12X, 13X, and 14X claims with condition code 41 written off in Stage 1 and the 48,347 76X bill types written off in Pre-Stage 1.