Medicare 2006 OPPS Final Rule Claims Accounting

CMS used information from over 87 million single and generated single procedure claim records to set the APC rates for services paid under Medicare OPPS for CY 2006. This compares favorably to the 2005 OPPS final rule in which CMS used 84 million single and generated single procedure claims to set payment weights for procedural APCs.[1] 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 final payment rates for Medicare's 2006 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 proposed unscaled weights were scaled for budget neutrality to ensure that the total amount of weight in the system was no greater for 2006 than it was for 2005. The proposed scaled weights were multiplied by the proposed 2006 conversion factor to determine the proposed national unadjusted payment rate for the APCs for 2006.

The purpose of this claims accounting is to help the public understand the order in which CMS processed claims to produce the proposed 2006 OPPS APC median costs, the proportion of claims that CMS used to set the proposed OPPS payment rates and the reason that not all claims could be used.

[1] Final 2006 rates are based on 2004 calendar year outpatient claims data, specifically final action claims processed through the common working file as of June 30, 2005. Final 2006 rates are based on one year (January 1- December 31) of 2004 outpatient claims data.

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 charge for the single unit of the major procedure. CMS estimates resource costs from the billed charges by applying a cost-to-charge ratio (CCR) to adjust the charges to cost. CMS used the most recent CCRs in the CMS HCRIS file in the calculation of the proposed weights. Wherever possible, departmental CCRs rather than each hospital's overall CCR 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 eliminate any of the copied information.

"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 2004 from the national claims history, n= 138,408,806 records with a total claim count of 137,715,340. 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=535,808). 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=1,730,254.

Balance = 135,449,278

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=26,276,140)

2) Bill types 12X, 13X, or 14X (hospital bill types). These claims are hospital outpatient claims. (n=109,059,540)

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=113,598)

Balance for Bill Types 12X, 13X, and 14X = 109,059,540

Applied hospital CCRs to claims and flagged hospitals with CCRs that will be excluded in Stage 1 below. We used the most recent CCRs that were available in the CMS HCRIS system.

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

Began with the set of claims with bill types 12X, 13X, or 14X, without MD, Guam or USVI, and with flags for invalid CCRs set, n=109,059,540

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=4,568,308.

Balance = 104,491,232

*Identified claims with condition code 41 and removed to another file, n= 41,306. These claims were combined with the 113,598 bill type 76X claims identified in Pre-Stage 1 to calculate the partial hospitalization per diem rate.

Balance = 104,449,926

Excluded claims without a HCPCS code = 11,900.

Balance = 104,438,026

***Removed to another file, claims for observation = 88,338

Balance = 104,349,688

Removed to another file claims that contain nothing but flu and PPV vaccine = 456,506.

Balance = 103,893,182

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=20,466,012. We use these line-items to calculate a per unit median and a per unit mean and a per day median and mean for drugs (including radiopharmaceuticals) and blood. We trimmed units at +/- 3 standard deviations from the geometric mean before calculating the median and mean costs per unit and per day. For drugs and biologicals, instead of using median cost as done in previous years, we used the October 1, 2005 ASP plus 6 percent and multiplied that amount by the average number of units per day for each drug or biological to arrive at its per day cost. For items that did not have an ASP, we used their mean unit cost derived from the CY 2004 hospital claims data to determine their per day cost.

In addition, although we will pay radiopharmaceuticals at charges reduced to cost by application of a cost to charge ratio, we used the per day mean cost to determine if the radiopharmaceutical would be packaged or paid separately.

The payment rates for blood and blood products were based on simulated median costs under a different methodology that is explained in the final rule.

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

Divided claims into 5 groups using the indicators (major, minor or bypass) that are assigned to each HCPCS code. The indicator is provided for each HCPCS code on each claim in the LDS and BEF. The indicators are J = major; M = minor; B = bypass.

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=33,771,061.

2) ***Multiple Major File:** Claims with more than one separately payable procedure and/or multiple units of "major" procedures, n=23,823,017. (These are examined carefully for dates of service and content to see if they can be divided into simulated or "pseudo" single claims.)

3) ***Single Minor File:** Claims with a single HCPCS that is not separately payable (which is called a "minor" procedure), n=97,938. 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. These claims cannot be considered to provide the costs of a single separately payable procedure without examining dates of service, n=690,613. (For example, pathologies are bypassed and not used 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 major claim for rate setting purposes.)

5) **Non-OPPS claims** These claims have no services payable under OPPS on the claim and are excluded, n=45,510,553. 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.

We look for a minor procedure on the claim. If the minor procedure is the only service on the claim and it has an APC assignment, the claim is elevated to a major procedure and becomes a single major. If 1) the minor procedure is the only service on the claim and 2) is not assigned to an APC, and 3) if there is only one unit of the code, then it becomes a single minor.

We then look for a major procedure on the claim. If there is one and only one major procedure on the claim and only one unit of the major procedure on the claim, then the claim becomes a single major and the minor code(s) are bypassed (charges are not used) unless they have a status indicator of SI=N. If there is more than one major procedure on the claim or more than one unit of a single major procedure on the claim, then the claim becomes a multiple major and the date of service stratification and bypass discussed below is applied. The minor procedures on multiple major claims would be used only if they are isolated during date of service testing and have an APC assignment. The rest of the claims (with no major procedures and with minor procedures that could not be elevated to major procedure state or single minor status) are written to the multiple minor file and are tested for date of service stratification. As in the multiple majors, minor procedures that are isolated during date of service testing and have an APC assignment are elevated to single major status. Claims in the multiple minor file that cannot be split by different dates of service or do not have an APC assignment are not used.

Balance = 58,284,69 (This is the sum of claims in files 1, 2, 3 and 4 above)

STAGE 3 Generated additional single claims or "pseudo singles" from multiple claims files

From the 23,823,017 multiple major claims, we were able to use some portion of 18,508,734 claims to create 54,069,380 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. Because bypass codes are thought to have limited packaging, we also used the line-item for the bypass code as a pseudo single. We were not able to use 5,161,016 claims because these claims continued to contain multiple separately payable procedures with significant packaging and could not be split. We also were not able to use claims with the following characteristics: major procedure with a zero cost (n=414,587), charges on a major separately paid procedure of less than $1.01 (n=51,208), or a payment flag of 3 (n=2,292). Claims with a payment flag of 3 were submitted with a charge of less than $1.01 for a major separately paid procedure but the charge other than the token charge was apportioned to the other separately paid procedures in claims processing; therefore the charge on the claims record is not used to set relative weights. These claims were excluded.

From the 690,613 multiple minor claims, we were able to use 375,775 multiple minor claims to create 923,731 pseudo single claims. We were not able to use 314,820 multiple minor claims for the same reasons discussed above, and they were excluded.

Balance =88,764,172 (the sum of single majors = 33,771,061, pseudo singles from multiple majors = 54,069,380 and pseudo singles from multiple minors = 923,731)

STAGE 4 Packaged costs into the payable HCPCS code

Began with, n=88,764,172 single procedure claim records that still had costs at the line-item level.

Completed packaging and left stage 4 with n= 88,764,172 single procedure claim records containing summarized costs for the payable HCPCS and all packaged codes and revenue centers on the claim.

Balance= 88,764,172

STAGE 5 Calculated HCPCS and APC medians

Began with n=88,764,172 single procedure claim records with summarized costs.

We excluded 2,228 claim records that had zero costs after summing all costs on the claim in Stage 4.

We excluded no claim records because CMS lacked an appropriate wage index.

We excluded 822,121 claim records that were outside +/- 3 standard deviations from the geometric mean cost for each HCPCS code.

Balance=87,939,823

We used the balance of 87,939,823 single procedure claims records 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").

We added a median for APC 339, Observation, which was calculated from the 88,338 claims written off in Stage 1 through a separate process. To calculate this median cost, we selected claims that contained at least 8 units of G0244, an office or ED visit, an allowed diagnosis, and did not contain a service with a status indicator of "T". We removed the line item costs for all payable services on the claim and packaged all remaining allowed costs (packaged revenue code costs and packaged HCPCS costs) into the line item cost for G0244. We used these claims records to calculate the median cost for APC 339, Observation.

We added a median per diem cost for APC 33, Partial Hospitalization. The per diem cost was calculated from the 41,306 bill type12X, 13X, and 14X claims with

condition code 41 written off in Stage 1 and the 105,798 bill type 76X claims written off in Pre-Stage 1.