Medicare 2005 OPPS Final Rule Claims Accounting

CMS used information from almost 84 million single and generated single procedure claim records to set the APC rates for services paid under Medicare OPPS for 2005 and used over 17 million individual claim line-items to set the APC rates for drugs and biologicals paid under OPPS for 2005. This compares favorably to the 2004 OPPS in which CMS used 44 million single and generated single procedure claims to set payment weights for procedural APCs and used 7 million individual line-items to set APC rates for drugs and biologicals.[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 payment rates for Medicare's 2005 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 2005 than it was for 2004. The scaled weights were multiplied by the 2005 conversion factor to determine the proposed national unadjusted payment rate for the APCs for 2005.

The purpose of this claims accounting is to help the public understand the order in which CMS processed claims to produce the 2005 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.

[1] Final rule 2005 rates are based on 2003 calendar year outpatient claims data, specifically final action claims processed through the common working file as of June 30, 2004. Final 2004 rates are based on nine-months (April-December) of 2002 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 same CCRs in the final rule as were used in the NPRM without further updating, to maximize stability in estimated costs. 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 2003 from the national claims history, n= 132,682,218 records with a total claim count of 132,178,555. 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=447,264). 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=1,717,235.

Balance = 130,014,056

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=23,930,166)
2) Bill types 12X, 13X, or 14X (hospital bill types). These claims are hospital outpatient claims. (n=105,991,922)
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=91,968)

Balance for Bill Types 12X, 13X, and 14X = 105,991,922

Applied hospital CCRs to claims and flagged hospitals with CCRs that will be excluded in Stage 1 below. As proposed in the NPRM, we used the same CCRs for the final rule that we used for the NPRM; we did not update for more recent data.

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=105,991,922

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

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identified as outliers (3 standard deviations from the geometric mean after removing error CCRs), n=3,732,540.

Balance = 102,259,382

*Identified claims with condition code 41 and removed to another file, n=42,594. These claims were combined with the 91,968 76X claims identified in Pre-Stage 1 to calculate the partial hospitalization per diem rate.

Balance = 102,216,788

Excluded claims without a HCPCS code = 6,385.

Balance = 102,210,403

*Removed to another file, claims for observation = 66,153

Balance = 102,144,150

Removed to another file claims that contain nothing but flu and PPV vaccine = 471,074.

Balance = 101,673,176.

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=17,410,385. We use these line-items to calculate a per unit median for drugs, blood, and devices.

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.

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=32,929,932
2) *Multiple Major File: Claims with more than one separately payable procedure and/or multiple units of “major” procedures, n=22,843,097. (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=773,519. These claims

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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=679,130. (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 for rate setting purposes.)

5) Non-OPPS claims These claims have no services payable under OPPS on the claim and are excluded, n=44,447,498. 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 = 56,452,159 (This is the sum of claims in files 1, 2 and 4 above)

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

From the 22,843,097 multiple major claims, we were able to use some portion of 17,314,630 claims to create 50,983,957 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 5,528,467 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 679,130 multiple minor claims, we were able to use 348,162 multiple minor claims to create 884,084 pseudo single claims. We were not able to use 330,968 multiple minor claims for the same reasons discussed above, and they were excluded.

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Balance =84,797,973 (the sum of single majors = 32,929,932, pseudo singles from multiple majors = 50, 983,957 and pseudo singles from multiple minors = 884,084)

STAGE 4 Packaged costs into the payable HCPCS code

Began with, n=84,797,973 single procedure claim records that still had costs at the line-item level.

Completed packaging and left stage 4 with n= 84,797,973 single procedure claim records containing summarized costs for the payable HCPCS and all packaged codes and revenue centers on the claim.

Balance= 84,797,973

STAGE 5 Calculated HCPCS and APC medians

Began with n=84,797,973 single procedure claim records with summarized costs.

Excluded 4,817 claim records that had zero costs after summing all costs on the claim in Stage 4.

Excluded 27 claims records from one provider because CMS lacked an appropriate wage index for the one provider.

Excluded 817,383 claim records that were outside +/- 3 standard deviations from the geometric mean cost for each HCPCS code.

Balance=83,975,746

We used the balance of 83,975,746 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").)

Added a median for observation, which was calculated from the 66,153 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 42,594 12X, 13X, and 14X claims with condition code 41 written off in Stage 1 and the 91,968 76X bill types written off in Pre-Stage 1.