

Introduction to HOPPS

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Definitions

- APC-Ambulatory Payment Classifications
- ASP-Average Sales Price
- BBA-Balance Budget Act
- CMS-Centers for Medicaid and Medicare
- DRA-Deficit Reduction Act
- HOPPS-Hospital Outpatient Prospective Payment System
- QIO-Quality Improvement Organizations
- MPFS-Medicare Physician Fee Schedule
- MedPAC-Medicare Payment Advisory Commission

History of HOPPS

- HOPPS mandated by Balanced Budget Act (BBA) of 1997
- April 7, 2000 CMS issued final rule on HOPPS 65 Fed. Reg. 18,434
- HOPPS went into effect August 2000
- Previously Medicare paid for services performed in hospital in a variety of methodologies based on reasonable costs

Prospective Payment vs FFS

- Fee for Service (FFS)
 - ✓ Granular
 - ✓ Physician Fee Schedule
- Prospective
 - ✓ Less granular
 - ✓ Incentives efficiency
 - ✓ Same payment regardless of resources used

APC

- Service divided into ambulatory payment classification (APCs)
- Each APC encompasses services that are clinically similar and require similar resources
- All services within an APC are generally paid at same prospectively-fixed rate.

Structure of APCs

- Hospitals report the codes on the claims and CMS does the translation to APCs and payments.
- Base payment rates on single procedure claims and pseudo single claims
- Pseudo single procedure claims are used by placing procedures on a bypass list
- HOPPS are geographically adjusted based on wage indices

Example of Use of Claims Data

| APC | Description | HCPCS Code | Status Indicator | Quantity | Units | Charge | CMS Data Processing |
|------|---------------------------|------------|------------------|----------|-------|--------|--|
| 0320 | X-ray exam of wrist | 73100 | X | 1 | 1 | \$50 | Single claim #1 on bypass list |
| 0320 | X-ray exam of elbow | 73070 | X | 1 | 1 | \$50 | Single claim #2 on bypass list |
| 0320 | X-ray exam of forearm | 73090 | X | 1 | 1 | \$50 | Single claim #3 on bypass list |
| 0250 | Drugs | J0880 | K | 1 | 20 | \$100 | Non-pass through drugs |
| | Cast Supplies | A4580 | E | 1 | 1 | \$20 | Not Covered Under OPPS |
| | Cast support arm - adult | Q4005 | B | 1 | 1 | \$15 | Not Paid Under OPPS |
| 0360 | Treat wrist bone fracture | 25670 | T | 1 | 1 | \$2000 | Single claim #4, separately paid procedure |
| 0370 | Anesthesia – lower arm | 01820 | N | 1 | 10 | \$60 | Packaged |

Cost-to-Charge Ratios

- Cost component – The cost reports are used to calculate a cost to charge ratio (CCR) for each department within each hospital and for the hospital as a whole.
- Charge component – The charges are those that are submitted on the claims for services which are from the department's charge master. Can represent multiple dates of service.
- The cost report departments are matched to the claims using the revenue code.
- CMS uses hospital-specific ancillary and departmental CCRs to convert charges to estimated costs through application of a revenue code-to-cost center crosswalk.
 - Hospital level
 - Department level
 - Modality level (e.g. CT and MR)
 - State-wide average default CCR. When no hospital cost report is available or a new hospital. Exist for every state urban and rural.

What Goes Into Calculating Payment Weights?

| Revenue Code | CCR | Charge | Cost |
|--------------|--------|---------|---------|
| 0250 | 0.3831 | 311.80 | 119.48 |
| 0761 | 0.6370 | 1189.50 | 757.71 |
| 0278 | 1.0600 | 1471.50 | 1560.08 |
| Total | | 2972.80 | 2437.27 |

RTI Charge Compression Study

- Charge compression states that hospitals do not mark-up their high-end studies at the same level as their low end studies/supplies.
- Therefore this causes a deflated cost-to-charge ratio (CCR) which underpays the high-end procedures.
- RTI charge compression study focused largely on charge compression in the context of the IPPS cost-based relative weights but CMS found areas relevant to OPFS.
- The RTI study reports the hospitals markup their CT and MR studies by 1800%. This is unrealistic.
- Adoption of CT and MR-specific CCRs under the RTI method would result in the payment of a CT (\$70) be less than an x-ray (\$90). DRA causes these low rates in both the office and hospital settings.
- ACR has commented on the hospital inpatient and hospital outpatient rules that it strongly opposes implementation of this methodology until further study.

Packaging

Medicare packaged many imaging services considered “ancillary” including contrast, diagnostic radiopharmaceuticals, imaging guidance, radiology supervision and interpretation codes and post processing (i.e. 3D and CAD)

Dependant service – Codes that represent services that are typically ancillary and supportive to a primary diagnostic or therapeutic modality.

Independent service – Codes that represent the primary therapeutic or diagnostic modality into which CMS packages payment for the dependant service.

Episodes of care – the development of larger payment groups that more broadly reflect services provided in an encounter. CMS proposes to build these larger groups based on independent services.

- Goal is to emulate the inpatient DRG prospective payment system.

CMS encourages hospitals to report all HCPCS codes that describe packaged services that were provided.

Problem – if packaged many say “we are not getting paid for it

Status Indicators for Packaging

Status indicators are assigned by CMS to HCPCS codes to indicate payment status

Status indicator “N” marks packaged services and represents that they are unconditionally packaged.

Conditionally Packaged (can be paid separately when a service exists on a claim alone)

Q1(STVX-Packaged Codes) – for Supervision and Interpretation Codes

Q2 (T-packaged Codes) – Packaged in Other Cases

Q3 (Codes that may be paid through a composite APC) – for Composite APCs

STVX-packaged code – a HCPCS code whose payment is packaged when one or more separately paid primary services with a status indicator of “S”, “T”, “V”, or “X” are furnished in an hospital outpatient encounter.

T-packaged code – a code whose payment is packaged when one or more separately paid surgical procedures with the status indicator “T”

Status Indicators

- G – Pass-Through Drugs and Biologicals
- H – Pass-Through Device Categories
- K – Nonpass-Through Drugs and Nonimplantable Biologicals, including Therapeutic Radiopharmaceuticals
- N – Items and Services Packaged into APC Rates
- P – Partial Hospitalization
- Q1 – STVX Packaged Codes
- Q2 – T-Packaged Codes
- Q3 – Codes that may be paid through a composite APC
- R – Blood and Blood Products
- S – Significant Procedure, Not Discounted When Multiple
- T – Significant Procedure, Multiple Reduction Applies
- U – Brachytherapy Sources
- V – Clinic or Emergency Department Visit
- X – Ancillary Services

Modifiers

CH – Status indicator or APC assignment has changed or active HCPCS code that will be discontinued at the end of the current calendar year.

NI – New code or existing code with substantial revision that is considered interim for the next calendar year and is open for comment. (ex. CT abd/pelvis)

FB modifier – signifies that the device was furnished without cost or with a full credit

FC modifier – signifies that the device was furnished with partial credit.

Composite APCs

Created to provide a single payment for groups of services that are typically performed together during a single clinical encounter and that result in the provision of a complete service.

- 1) Extended assessment and management
- 2) Low dose rate (LDR) prostate brachytherapy
- 3) Cardiac electrophysiologic evaluation and ablation services
- 4) Mental health services
- 5) Multiple imaging

Five Imaging Composite APCs

- The imaging composite APCs are:
 - US, CT/CTA with contrast, CT/CTA without contrast, MR/MRA with contrast, MR/MRA without contrast.
- Meant to address MedPACs continue comments that the multiple procedural reduction rule should be applied in the hospital outpatient setting.
- When two of these studies are done in the same session, hospitals report on same claim and one bundled payment is paid.
- Current assessment is that this policy is budget neutral to hospitals (i.e. payment is a factor of 2) however when 3 or more are done, analysis shows that reimbursement will be cut by 75%.

Imaging Composites

APC 8004 Ultrasound

APC 8005 CT and CTA without Contrast

APC 8006 CT and CTA with Contrast

APC 8007 MRI and MRA without Contrast

APC 8008 MRI and MRA with Contrast

Reported for same date of service. Not same session.

Imaging Composites

Hospital reports their costs the same. CMS' system converts the claims submission into composite APC.

“we do have the capacity to examine claims data for patterns of fragmented care. If we find a pattern of change in how claims are reported

Deficit Reduction Act (DRA) and HOPPS

- Applied HOPPS payments to MPFS for outpatient Radiology exams

Activities

- Review of Proposed Rule by Committee
- Letter on Proposed Rule
- Meeting with Medicare Staff
- Review of Final Rule
- Letter on Final Rule

- CMS APC Advisory Panel meets twice per year

Meeting with Medicare Staff

- Annual ACR meeting with CMS staff
- Including Moran Company
- Focus on New CPT codes
- CMS needs to assign payments to new CPT codes on short time schedule for Final Rule
- No hospital data for new CPT codes to set charges
- Using CMS methodology and data, ACR develops cross walk between old CPT codes (predecessor codes) and new CPT codes and presents it to CMS

New CPT Codes- Opportunity to bring value

- ACR working with CMS to develop new payments for HOPPS
- ACR working with Hospitals to update their charge masters on new CPT codes
- What did you do to prepare for new codes in January 2014?
- How did your hospital prepare?

New CPT Codes

- Proposed assignment of new codes presented to CMS
- Abscess drainage codes (10030, 49407)
 - Assignment to different APCs despite all codes are abscess drainage varying in body part
- New Breast Biopsy Codes (19081-19086)
 - Assigned to same APCs
 - Difference in cost of biopsy devices
- ACR met proactively with CMS prior to Final Rule to recommend assignment of new CPT codes based on clinical and resource similarities
- ACR and other stakeholders presented at HOP Advisory Panel March 10, 2014

Payment for Drugs

- Diagnostic radiopharmaceuticals are packaged
- Therapeutic radiopharmaceuticals are paid separately when the cost is above the \$90 threshold for 2014
- Devices are packaged into device-dependant APCs
- Brachytherapy seeds paid separately

Pass-through Payments

- Pay for new drugs separately
- CMS usually pays for up to 3 years but usually only 2
- Offset is out of APC Payment
- For contrast agents, diagnostic radiopharmaceuticals and implantable biologicals, the pass-through payment is equal to the difference between the policy-packaged offset amount associated with an APC and the payment rate specified of ASP+6%.
- Current example, new *Beta Amyloid Positron Emission Tomography (PET) Imaging, Per Study Dose*

New Technologies in APCs

- There are new technology APCs.
- The cost bands for New Technology APCs range from \$0 to \$50 in increments of \$10, from \$50 to \$100 in increments of \$50, from \$100 to \$2,000 in increments of \$100, and from \$2,000 to \$10,000 in increments of \$500.
- CMS placing new technologies in current APCs.
- Example of category III placements.
- Concern not set on actual charges and costs of procedures. Presetting a price based on their placement.
- New technology placement for 2015 will be for tomosynthesis.

| Diagnostic Study | APC Placement | 2014 Proposed Rate | Status Indicator | Grouped With |
|---|--|--------------------|------------------|--|
| 74261 Diagnostic CT Colongraphy without Contrast | 0332 CT without contrast, single study | \$126.47 | Q3 | 70450, 70480, 70486, 70490, 71250, 72125, 72128, 72131, etc. |
| 74262 Diagnostic CT Colongraphy with Contrast Note: includes CM code | 0283 CT with contrast, single study | \$249.00 | Q3 | 70460, 70481, 70487, 70490, 71260, 72126, 72129, 72132, etc. |
| 74263 Screening CT Colongraphy | Not covered under HOPPS | N/A | N/A | N/A |

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Five Imaging Composite APCs

The imaging composite APCs are:

- APC 8004 Ultrasound
- APC 8005 CT and CTA without Contrast
- APC 8006 CT and CTA with Contrast
- APC 8007 MRI and MRA without Contrast
- APC 8008 MRI and MRA with Contrast

Reported for same date of service. Not same session.

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Imaging Composites

Hospital reports their costs the same. CMS' system converts the claims submission into composite APC.

“we do have the capacity to examine claims data for patterns of fragmented care. If we find a pattern of change in how claims are reported, we will alert the QIO”

Calculation of Payment Rates

| CT & CTA without contrast Composite APC 8005 | Payment Rate |
|---|--------------|
| 2012 | \$431.91 |
| 2013 | \$400.28 |
| 2014 | \$306.30 |

Placement of New Bundled Codes

- Annual ACR meeting with CMS staff
- Including Moran Company
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What's Next?

New codes for 2015?

- DXA – dual x-ray absorbiometry
- myelography
- Isodose planning
- IMRT – intensity modulated radiation therapy
- Vertebroplasty

Go to www.acr.org for full article in the 2014 April/May ACR Radiology Coding Source

New CPT Codes- Opportunity to Bring Value

- ACR working with CMS to develop new payments for HOPPS
- ACR working with hospitals to update their charge masters on new CPT codes
- What did you do to prepare for new codes in January 2014?
- How did your hospital prepare?

How Can You Help?

- Work with your hospitals to keep your charge master current
- Encourage your hospitals to bill for services even if they are not directly reimbursed for them-used in calculations for reimbursement
- Hospital charges drive HOPPS reimbursement

Additions

| CPT Category I | Descriptor | Comments |
|---|---|---|
| <ul style="list-style-type: none"> ● 78452 | <p>Myocardial perfusion imaging, tomographic (<u>SPECT</u>) (<u>including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed</u>); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection</p> | <p>Crosswalk 78465 plus 78478 & 78480</p> |

Did you update your Charge Description Master (CDM)?

- Department #
- Item #
- Description
- CPT/HCPCS Code
- Revenue Code (RC)
- Price

| Dept # | Item # | Limited Description | CPT/HCPC | RC | Price | Active Code | Deactivation/Date |
|--------|--------|-------------------------------------|----------|------|------------|-------------|-------------------|
| 302 | 18490 | MPI wall motion | 78478-TC | 0341 | \$300.00 | N | 1/1/2010 |
| 302 | 18491 | MPI ejection fraction | 78480-TC | 0341 | \$200.00 | N | 1/1/2010 |
| 302 | 55501 | MPI, SPECT, Multiple | 78465-TC | 0341 | \$1,500.00 | N | 1/ 1/2010 |
| 302 | 55523 | MPI SPECT Multiple WM&EF | 78452-TC | 0343 | \$2,000.00 | Y | New |
| 302 | 40325 | 99mTc MIBI, <u>PSD</u> | A9500 | 0343 | \$120.00 | Y | |
| 302 | 40330 | 201Thallium, <u>Per mCi</u> | A9505 | 0343 | 30.00 | Y | |
| 302 | 60235 | Inj, regadenoson, <u>per 0.1 mg</u> | J2785 | 0636 | \$80.00 | Y | |

PSD = per study dose

Radiology Management

AHRA publication for Radiology Administrators

March/April 2014 Issue

Pricing Radiology Bundled CPT Codes Accurately in the Hospital Outpatient Setting

Pam Kassing, Melody Mulaik, Jim Rawson

<http://www.radiologymanagement-digital.com/radiologymanagement/20130304?pg=11#pg11>

New CT and MR Cost Centers

Final rule released on November 27 with 60 day comment period.

- For 2014, CMS is using FY 2011 cost data to establish separate cost centers for CT and MR, distinctly separate from the diagnostic and therapeutic radiology cost centers for pricing out payments for CTs and MRs in the hospital outpatient setting.
- Based on a Research Triangle Institute (RTI) report
- Analysis done on payment rates from these cost centers would result technical payment for CTs (\$85) to be paid at the same level as a chest x-ray (\$84).
- Further problems with this policy is that this proposal in HOPPS affects the technical component payments in the Physician Fee Schedule (PFS) when the lower-of-the-two payment policy is applied as mandated by the Deficit Reduction Act (DRA).

Calculation and Use of Cost-to-Charge Ratios CT and MR Cost Centers

CMS decides to move forward with this policy but excludes data where hospital use the “square feet” cost allocation method. This only improves the cuts by about 4-5%.

CMS is allowing for a 4-year period for hospitals to convert to the direct cost or dollar allocation methods.

ACR has tried to replicate this methodology with CMS data and therefore the cuts and it can't be done.

For hospitals, increases in some payment categories could outweigh the decreases others so the aggregate effect of this policy may not be as significant as initially anticipated.

Calculation and Use of Cost-to-Charge Ratios

CT and MR Cost Centers (cont.)

- However, since CMS pays only the lower of the hospital outpatient or physician fee schedule rate for the technical component in the PFS the corresponding increases are not realized.
- ACR met with the Office of Management and Budget when this rule was going through clearance for the hospital inpatient proposed rule and met twice with Medicare to request that this proposed policy not appear in the outpatient rule.
- ACR presented testimony before the Hospital Outpatient Payment (HOP) Panel on March 10th on the CT and MR cost center data. The purpose is to tease out an explanation to CMS on how they got to the 2014 payment levels.
- ACR's ask is do not implement use of CT/MR CCRs for 2014 and in future years.
- ACR continues to work with CMS to find an improved methodology

Impacts on Hospitals Using the CT and MR Cost Center Data

| Code | Short Descriptor | 2013 SI | 2013 APC | 2013 Relative Weight | 2013 Payment Rate | SI 2014 | APC 2014 | Relative Weight 2014 | Payment Rate 2014 | % diff 2013 and 2014 |
|-------|-----------------------------|---------|----------|----------------------|-------------------|---------|----------|----------------------|-------------------|----------------------|
| 75571 | Ct hrt w/o dye w/ca test | X | 340 | 0.6961 | \$49.64 | X | 35 | 0.3042 | \$22.11 | -55% |
| 70450 | Ct head/brain w/o dye | Q3 | 332 | 2.4340 | \$173.58 | Q3 | 332 | 1.7403 | \$126.47 | -27% |
| 74176 | Ct abd & pelvis | Q3 | 331 | 4.2917 | \$306.05 | Q3 | 331 | 3.3271 | \$241.79 | -21% |
| 76497 | Ct procedure | S | 282 | 1.3864 | \$98.87 | S | 282 | 1.0948 | \$79.56 | -20% |
| 74174 | Ct angio abd&pelv w/o&w/dye | S | 334 | 6.7671 | \$482.58 | S | 334 | 5.3683 | \$390.13 | -19% |
| 75572 | Ct hrt w/3d image | S | 383 | 3.7468 | \$267.20 | S | 383 | 3.0549 | \$222.01 | -17% |
| 70460 | Ct head/brain w/dye | Q3 | 283 | 4.1669 | \$297.15 | Q3 | 283 | 3.4263 | \$249.00 | -16% |
| 70470 | Ct head/brain w/o & w/dye | Q3 | 333 | 4.6182 | \$329.34 | Q3 | 333 | 3.8584 | \$280.40 | -15% |
| 70496 | Ct angiography head | Q3 | 662 | 4.7570 | \$339.24 | Q3 | 662 | 4.0175 | \$291.96 | -14% |
| 70540 | Mri orbit/face/neck w/o dye | Q3 | 336 | 4.7466 | \$338.49 | Q3 | 336 | 4.0563 | \$294.78 | -13% |
| 70553 | Mri brain stem w/o & w/dye | Q3 | 337 | 7.7051 | \$549.47 | Q3 | 337 | 6.7828 | \$492.92 | -10% |
| 70542 | Mri orbit/face/neck w/dye | Q3 | 284 | 6.3741 | \$454.56 | Q3 | 284 | 5.8687 | \$426.49 | -6% |

Establishing Comprehensive APCs

For CY 2014, CMS created 29 comprehensive APCs to prospectively pay for the most costly device-dependent services. However, they haven't finalized any decisions on how to calculate the payments.

This is Medicare's way of moving closer to establishing episodes-of-care for hospital outpatient services.

The comprehensive APC would pay a single prospective payment based on the cost of all individually reported codes on the claim that represent the delivery of a primary service as well as all adjunct services provided to support that delivery.

CMS defines "adjunctive services," as any service that is integral, ancillary, supportive, and/or dependent to the primary service. This includes:

- (1) Drugs, biologicals, and radiopharmaceuticals that function as supplies in a diagnostic test or procedure;
- (2) Drugs and biologicals that function as supplies or devices in a surgical procedure;
- (3) Laboratory tests;
- (4) Procedures described by add-on codes;
- (5) Ancillary services (status indicator "X");
- (6) Diagnostic tests on the bypass list; and
- (7) Device removal procedures.

Increased Packaging for Imaging Services

Comprehensive APCs (cont):

Two of these APCs include about 85% of all the packaged imaging.

The ACR is currently analyzing the methodology and further packing of imaging procedures and will meet with CMS to present their findings.

Further Packaging:

CMS is contemplating a proposal for CY 2015 that would conditionally package all imaging services with any associated surgical procedures. Imaging services not provided with a surgical procedure would continue to be paid separately paid.

CMS requested public comments on this potential CY 2015 proposal.

This is one further step towards scattering radiology revenue into various other hospital departments.

Future Directions for HOPPS

- HOPPS is NOT a few schedule
- It is a prospective payment system
- Packaging-Bottom up combination of codes commonly performed together adjunct to a primary procedure e.g. contrast agents, radioisotopes, stress agents
- Comprehensive APC-Top down; Primary procedure identified, then everything else packaged into it.
 - Replacing device dependent APCs.
- Future: more prospective, more codes combine

Take Home Messages

- Establish a relationship with hospital finance
- Review your charge master annually
- Work with your hospital to review new CPT codes and charges set for those new codes
- Report all costs accurately and include all supplies, devices, etc.

Questions?

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