ONLINE APPENDIXES 2

Medicare payment differences across ambulatory settings

ONLINE APPENDIX 2–A

Ambulatory payment classifications in Group 1 and Group 2

TABLE 2–A1

66 APCs in Group 1 and Group 2 (continued, next page)

APC	APC description
Group 1	
1	Level 1 photochemotherapy
60	Manipulation therapy
73	Level III endoscopy upper airway
96	Level II noninvasive physiologic studies
209	Level II extended EEG, sleep, and cardiovascular studies
216	Level III nerve and muscle tests
265	Level I diagnostic and screening ultrasound
267	Level III diagnostic and screening ultrasound
269	Level II echocardiogram without contrast
288	Bone density: axial skeleton
336	MRI and magnetic resonance angiography without contrast
363	Level I otorhinolaryngologic function tests
364	Level I audiometry
365	Level II audiometry
366	Level III audiometry
370	Allergy tests
373	Level I neuropsychological testing
381	Single allergy tests
382	Level II neuropsychological testing
660	Level II otorhinolaryngologic function tests
678	External counterpulsation
689	Level II electronic analysis of devices
690	Level I electronic analysis of devices
698	Level II eye tests and treatments
Group 2	
2	Fine needle biopsy/aspiration
12	Level I debridement and destruction
13	Level II debridement and destruction
15	Level III debridement and destruction
17	Level VI debridement and destruction
19	Level I excision/biopsy
20	Level II excision/biopsy
74	Level IV endoscopy upper airway
78	Level III pulmonary treatment
121	Level I tube or catheter changes or repositioning

Note: APC (ambulatory payment classification), EEG (electroencephalography), IMRT (intensity-modulated radiation therapy).

Source: MedPAC analysis of 2010 5 percent Standard Analytic Claims files for physician and hospital outpatient claims.

TABLE 2–A1

66 APCs in Group 1 and Group 2

APC	APC description
126	Level I urinary and anal procedures
142	Small intestine endoscopy
146	Level I sigmoidoscopy and anoscopy
156	Level III urinary and anal procedures
160	Level I cystourethroscopy and other genitourinary procedures
188	Level II female reproductive procedures
191	Level I female reproductive procedures
192	Level IV female reproductive procedures
203	Level IV nerve injections
204	Level I nerve injections
206	Level II nerve injections
207	Level III nerve injections
215	Level I nerve and muscle tests
218	Level II nerve and muscle tests
231	Level III eye tests and treatments
238	Level I repair and plastic eye procedures
239	Level II repair and plastic eye procedures
270	Level III echocardiogram without contrast
275	Arthrography
300	Level I radiation therapy
341	Skin tests
344	Level IV pathology
368	Level II pulmonary tests
369	Level III pulmonary tests
377	Level II cardiac imaging
383	Cardiac computed tomographic imaging
412	IMRT treatment delivery
426	Level II strapping and cast application
428	Level III sigmoidoscopy and anoscopy
440	Level V drug administration
692	Level III electronic analysis of devices
699	Level IV eye tests and treatments

Note: APC (ambulatory payment classification), EEG (electroencephalography), IMRT (intensity-modulated radiation therapy).

Source: MedPAC analysis of 2010 5 percent Standard Analytic Claims files for physician and hospital outpatient claims.

ONLINE APPENDIX 2-B

Methods for aligning payment rates between settings

Overview

Most Medicare-covered services provided in hospital outpatient departments (OPDs) are paid under the outpatient prospective payment system (OPPS). The OPPS classifies services that have similar costs and clinical characteristics into ambulatory payment classifications (APCs). All services—as defined by Current Procedural Terminology (CPT) codes—in the same APC have the same payment rate in the OPPS.

In this chapter, we have used five criteria to identify APCs that could have the same Medicare payment rate whether they are provided in an OPD or in a freestanding physician's office:

- The services in an APC are frequently performed in freestanding physicians' offices, which we define as at least 50 percent of the volume of services that are provided in freestanding offices and OPDs being performed in OPDs. This indicates that the services in an APC are likely safe and appropriate to provide in freestanding offices and that payments in freestanding offices are adequate to ensure beneficiaries' access to care.
- The OPPS has minimal packaging of ancillary items with primary services within the APC in question. We define minimal packaging as the cost of packaged items being less than 5 percent of the total cost hospitals incur when they provide the services in an APC. This is important because the physician fee schedule (PFS), which is the system that Medicare uses to reimburse physicians and other health professionals, pays separately for most ancillary items and does not package them with a primary service. In contrast, the OPPS often packages ancillary items with primary services to a greater degree than the PFS.
- When furnished in an OPD, the services in an APC are provided on the same day or appear on the same claim as an emergency department (ED) visit less than 10 percent of the time (such services are unlikely to have costs that are directly associated with operating an ED).
- Less than 5 percent of the OPD volume in an APC involves CPT codes that have 90-day global surgical periods under the PFS. The PFS assumes that physicians incur additional costs when providing procedures with 90-day global periods in a hospital than in a freestanding office because physicians' clinical staffs spend more time scheduling procedures and coordinating presurgical services when they are performed in a hospital. Because we are unable to estimate the amount of the additional cost incurred when these procedures are delivered in a hospital, we excluded them from the group of services that are candidates for equal payment rates across settings.
- For a given APC, patient severity is no greater in OPDs than in freestanding offices.

Using data from Medicare claims and payment systems from 2010, we identified 24 APCs that met the criteria for equal payment amounts across settings. In this chapter, we refer to these 24 APCs as Group 1.

We also identified 42 APCs that met four of the criteria but have relatively high packaging of ancillary items under the OPPS, so they failed to meet that criterion. For these APCs, which we refer to as Group 2, Medicare could allow the OPD rate to exceed the freestanding office rate by an amount equal to the cost of the additional packaging in the OPPS.

Description of method

We will use APC 269—level II echocardiogram without contrast—to illustrate our method. In 2010, this APC consisted of five CPT codes: 76826, 93304, 93306, 93313, and 93350.

Volume in freestanding offices and OPDs

We used the 5 percent Standard Analytic Claims file from 2010 to estimate volume of services that were provided in OPDs and in freestanding offices. These claims files are random samples of 5 percent of the Medicare fee-for-service (FFS) population. We found that, in APC 269, volume was about 173,400 in freestanding offices and 59,300 in OPDs. Extrapolating to the full Medicare FFS population, the volume in APC 269 was about 3,468,000 in freestanding offices and 1,186,000 in OPDs. Therefore, 74.5 percent of the volume in APC 269 occurred in freestanding offices in 2010.

Determining the cost of packaged items as a percent of total cost

To determine the extent of packaging in each APC, we used the 2010 outpatient facility claims that CMS used to

determine OPPS payment rates for 2012. For APC 269, we identified all claims that had one of the CPT codes from APC 269 and did not have any other CPT codes that are separately paid under the OPPS. Using claims that only had one of the CPT codes for APC 269 assured us that all of the packaged items on the claim were packaged with the CPT code from APC 269. If a claim had an additional CPT code that was separately paid under the OPPS, we could not be certain if the packaged items were furnished with the CPT code from APC 269 or the other separately paid CPT code. We identified packaged items as those lines on each claim that had a status indicator of N or Q1 or a revenue code that is always packaged as indicated in the 2010 final rule for the OPPS.[1,2] On these claims, CMS estimated a cost for each line. For APC 269, we summed the cost of all packaged items and compared it with the sum of the cost of all packaged items plus the cost of all lines that have CPT codes in APC 269. For APC 269, the cost of the packaged items was about 0.8 percent of the total cost. We followed the same procedure to estimate the extent of packaging in all other APCs.

Determining frequency of ED visits

We identified claims from the 2010 5 percent Standard Analytic Claims files that had CPT codes in APC 269. We determined how frequently these CPT codes were provided on the same date of service or appeared on the same claim as an ED visit. We identified ED visits as lines on claims that had either

- a CPT code of 99281, 99282, 99283, 99284, 99285, G0380, G0381, G0382, G0383, or G0384, or
- a revenue center code of 450, 451, 452, or 459.

We found that the CPT codes in APC 269 were provided on the same day or appeared on the same claim as an ED visit about 8 percent of the time.

Determining frequency of codes with 90-day global periods

We used the 2010 5 percent Standard Analytic Claims files to determine the total volume in OPDs for each CPT code in each APC. Next, we identified which CPT codes had 90-day global surgical periods in the PFS. We then determined the percent of OPD volume in each APC that was related to CPT codes that have 90-day global periods. None of the CPT codes in APC 269 had 90-day global periods in 2010.

Determining differences in patient severity

For each APC, we used beneficiaries' 2010 risk scores from the CMS–hierarchical condition categories (CMS–HCC) risk-adjustment model to evaluate differences in patient severity between OPDs and freestanding offices. CMS uses the CMS–HCC risk-adjustment model in Medicare Advantage to measure patient severity. This model, which includes 70 disease categories, is an abbreviated version of the full HCC model, which includes 189 disease categories. CMS–HCC risk scores predict beneficiaries' relative costliness based on diagnoses from the prior year and demographic information. Beneficiaries who have higher risk scores are likely to be sicker and may require more time and resources to treat.

We obtained CMS–HCC risk scores from CMS. For each APC, we used the 2010 100 percent Standard Analytic Claims files to identify beneficiaries who received services in OPDs and those who received services in freestanding offices. For each APC, we determined mean risk scores for beneficiaries who received care in OPDs and those who received care in freestanding offices. Next, we determined standard errors of the mean risk scores. We used the means and standard errors to create z-scores. For APC 269, the mean risk score was 1.57 for patients in OPDs and 1.48 for patients in freestanding offices. Combining these means with the appropriate standard errors produced a z-score of 1.19, which has a *p*-value of 0.23. Under a two-tail test at a 0.05 level of significance, we did not reject a null hypothesis that these two mean risk scores were equal. In other words, the mean OPD risk score was not statistically higher than the mean freestanding office risk score.

Assigning APCs to Group 1 and Group 2

We assigned APCs that met the five criteria listed above to Group 1 and those that met four of the five criteria—but had packaged ancillary items that are more than 5 percent of an APC's total costs—to Group 2. APC 269 met all five criteria, so we assigned it to Group 1. APC 270—level III echocardiogram without contrast—met four of the criteria, but packaged ancillary items were nearly 30 percent of its total cost, so we assigned it to Group 2. We excluded from the analysis APCs that failed any of the other four criteria.

Adjusting OPPS payment rates to align payments across settings

After we identified the APCs for Group 1 and Group 2, we adjusted OPPS payment rates for Group 1 so that the total payment rates for services in those APCs would be the same whether they are provided in OPDs or in

freestanding offices. We also adjusted OPPS payment rates for Group 2 so that payment differences would be narrowed between settings but differences would remain to account for additional packaging in the OPPS. See Table 2-3 (p. 39) and Table 2-4 (p. 40) in the text of this chapter for an illustration of these adjustments for APCs 269 and 270.

An issue we addressed is that the APCs in the OPPS are made up of multiple CPT codes that have the same payment rate, while the PFS does not use APCs and each CPT code has its own distinct payment rate. In 2010, the year of our analysis, APC 269 had a payment rate of $450 in the OPPS, while the payment rates under the PFS ranged from $41 for CPT code 93313 to $239 for CPT code 93306 when performed in freestanding offices.

We performed the following steps to adjust the OPPS payment rate for APC 269 so that the total Medicare payment rate would be equal between OPDs and freestanding offices:

- For each CPT code in APC 269, we identified the nonfacility practice expense (PE) rate and facility PE rate from the PFS. The nonfacility PE rate is intended to reflect the direct and indirect resources needed to provide a service in an office. Direct resources can be linked to a specific service and include the cost of nonphysician clinical staff, medical equipment, and medical supplies. Indirect resources are difficult to link to a specific service and include administrative staff, rent, utilities, and other overhead expenses. The facility PE rate is intended to reflect the resources needed to provide a service in a facility, such as an OPD. It includes indirect resources but excludes direct resources because the facility—not the practitioner—provides the clinical staff, medical equipment, and medical supplies used for the service.
- For each CPT code, we calculated the difference between the nonfacility PE rate and facility PE rate, which we refer to as the PE difference. If the OPPS payment rate for a service is set equal to the difference between the service's nonfacility PE rate and its facility PE rate, the total Medicare payment rate for that service will be the same whether it is done in an OPD or in a freestanding office (see Table 2-3, p. 39, in the text of this chapter).
- We calculated a weighted mean of the PE differences for the five CPT codes in APC 269 using 2010 payment rates. The weights were the volume of each CPT that was performed in OPDs in 2010. For this APC, the weighted mean of all the PE differences was $165. Because CPT code 93306 accounted for over 90 percent of the volume of APC 269, its PE difference ($169) had a disproportionate impact on the APC mean. We trended the mean PE difference of $165 forward to 2012 using the cumulative update to the PFS conversion factor from 2010 to 2012, which was about 2.2 percent. This resulted in a PE difference of $168 for APC 269.

Method for identifying APCs that could have equal payments in OPDs and ambulatory surgical centers

In this chapter, we also identified 12 APCs that met criteria for equal payment rates in OPDs and ambulatory surgical centers (ASCs). The method we used to identify those 12 APCs was similar to the method we used to identify APCs in Group 1 and Group 2, with the following differences:

- We did not have to address differences in the packaging of ancillary items between payment systems because the OPPS and the ASC payment system use the same packaging rules.
- We did not have to address the issue of codes with 90-day global periods because neither the OPPS nor the ASC payment system pays on the basis of 90-day global periods.

The ASC payment system has a single rate for each CPT code that it covers. For all CPT codes, the ASC rate is lower than the OPPS rate. For most codes, the ASC rate equals the OPPS relative weight for that code multiplied by the ASC conversion factor (which is lower than the OPPS conversion factor). CMS uses a different method to determine ASC payment rates for new, office-based procedures. The rates for these procedures are based on the lower of the ASC rate (as determined using the OPPS relative weight) or the PE portion of the PFS rate that applies when the service is furnished in a physician's office. To equalize payment rates in OPDs and ASCs for a particular APC, we calculated a revised OPPS rate that equals a weighted mean of the ASC payment rates for the CPT codes in that APC. The weights are the volume of each CPT code that was performed in OPDs in 2010.

Caveat

The results from our method are based on data and payment rates from 2010. If we had used data from a different year, we may have produced slightly different results. ■

Endnotes

1 On a claim, a line is a collection of information about a service provided or an input to a service. Information on a line includes such items as the CPT of the service provided, the charges from the provider, an identification number of the provider, the date of service, and so on.

2 The OPPS uses status indicators to indicate the status of each CPT code. The OPPS currently has 20 status indicators. Some indicate that a CPT code is not paid under the OPPS, others indicate that a CPT code is paid under the OPPS but packaged with a primary service, and others indicate that a CPT code is paid separately under the OPPS.