What would be an appropriate adjustment factor if all hospital outpatient services were paid under the OPPS?

Issue: The Official Medical Fee Schedule (OMFS) allows a facility fee for emergency department (ED) and outpatient surgical services as well as inpatient services. The maximum allowable fees are set at 120 percent of what Medicare would pay for a comparable service under its outpatient prospective payment system (OPPS). Other services- largely radiology and clinic services- have been paid under the OMFS for physician services. These services account for approximately 9 percent of total hospital outpatient facility allowances.[1] No separate facility fee was payable for these services under the pre-2014 OMFS.

Under the pre-2014 physician fee schedule, the allowance for a physician service did not vary based on whether the service was provided in a facility setting such as a hospital outpatient clinic or a non-facility setting such as a physician office. For radiology and other diagnostic tests, there are separate allowances for the technical component for the actual procedure (e.g., taking an X-ray) and a professional component for supervision and interpretation of the results. The technical component is comparable to a facility fee and covers the technician, equipment, space and supply costs for the procedure. In a typical arrangement, a hospital might bill for the technical component while the physician might bill for the professional component. Alternatively, the hospital might bill for the full service and compensate the physician for interpreting the results. The sum of the allowances for the technical and professional components equals the allowance for the complete service so that the billing arrangement does not affect the total allowance. By paying for the TC under the physician fee schedule, the OMFS allowance is the same regardless of where the service is provided to an ambulatory patient (hospital, radiology center, or physician office).

For services such as clinic visits that do not involve separate technical and professional components, the RBRVS allowance for the practice expense (PE) component of the service varies by where the service is provided. The physician's PE allowance is lower when a service is furnished in a facility setting than in a non-facility setting such as a physician office. The assumption is that the facility assumes the staffing, space, and equipment costs for the service and that the physician only has indirect PE costs, e.g., expenses for office staff involved in scheduling and billing. Unlike the pre-2014 OMFS, the RBRVS assumes that a separate facility fee is payable under the payment system applicable to the facility, i.e., the OPPS for hospital outpatient services.

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[1] Allowances for surgical and ED services account for 91 percent to total allowances for hospital outpatient services. Services paid under the RBRVS account for 7.5 percent of allowances. "Facility-only" services, clinical laboratory services , and pharmaceutical services that are separately billed as hospital outpatient services each account for less than 0.5 percent of allowances.

When DWC implemented the RBRVS fee schedule for physician services, separate rulemaking was undertaken for hospital outpatient services. Effective September 1, 2014, the general approach of paying for services under the physician fee schedule continued but with a separate facility fee payable to the hospital in addition to the RBRVS allowance for the physician service. Generally, the facility fee allowances equal 1) 120 percent of the OPPS for services that are an integral part of an ED or surgical services, 2) 120 percent of the Medicare PE component for non-facility services or the TC for services that are payable under both the OPPS and the RB-RVS, and 3)100 percent of the OPPS for "facility only" services for which there is no PE component for services provided in a non-facility setting. Meshing the two Medicare payment systems into a consistent and coherent OMFS for hospital outpatient services was complex from the outset but recent Medicare changes to the OPPS have made it more challenging to do so.[2] Covering all services under the OPPS would reduce payment system complexities and regulatory burden. However, it would also increase maximum allowable fees for hospital outpatient services unless the 120 percent adjustment factor is reduced so that there would be no change in estimated aggregate allowances.

Objective: Estimate an adjustment factor that would result in estimated aggregate allowances using the OPPS facility rates for all hospital outpatient services that would equal estimated allowances for hospital facility fees under the current rules applicable to services provided to hospital outpatients.

Method: Our estimate draws on 2014 billing data for physician services from the Workers' Compensation Information System (WCIS). These data reflect implementation of the RBRVS for physician services effective January 1, 2014 and the revised payment methodology for hospital outpatient services effective September 1, 2014. An advantage of using these data is that the most codes that were used to bill for 2014 services can be used to price 2016 allowances; only codes that were deleted in 2014 or 2015 need to be crosswalked into 2016 CPT codes.[3] A disadvantage is that because of billing lags, the data for the latter part of 2014 is under-reported in the WCIS. Because the data are predominately from the pre-RBRVS for hospital billings, they do not fully account for changes that might have been made in hospital billing practices and facility fee allowances when the RBRVS was implemented in September 2014 and may not be representative of services furnished post-RBRVS.[4]

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[2] Two issues are paying for services that are ordinarily payable only in a non-facility setting and outpatient clinic visits, where different codes are used for purposes of billing under the OPPS and the RBRVS.

[3] Because the revised payment policies for hospital outpatient services were not implemented until September 1, 2014, hospitals continued to bill services paid under the OMFS physician fee schedule using the pre-2014 codes. Fifty-seven of the 647 codes reported in the WCIS for hospital outpatient services that were paid under the physician fee schedule (exclusive of therapy services) required crosswalking from outdated CPT codes. In addition, 125 codes used in 2014 required crosswalking to 2016 codes. We used the RBRVS crosswalk files to estimate utilization counts for the 2016 codes that replaced the deleted 2014 codes.

[4] The WCIS data for clinic visits is particularly problematic in this regard. Medicare replaced the CPT clinic visit codes (99201-99205 (new patient visit), 99211-99215 (established patient visit)) with a single G-code for outpatient clinic visits (G0463) in 2014. For physician services, the CPT codes continue to apply. This has created a Catch-22

Our focus is on the change in total facility allowances for hospital outpatient services under the RBRVS/OPPS vs. OPPS options. We compare estimated facility fees under current rules to those that would apply if the OPPS rates applied to all services, including the impact that the change would have on payments for clinical laboratory tests that are paid separately when provided in conjunction with services paid under the RBRVS but are typically included in the OPPS allowances. Effective January 1, 2015, Medicare implemented significant changes in its OPPS by establishing an expanded package of services (Comprehensive Ambulatory Payment Classifications (C-APCs) that are included in the payment for device-intensive outpatient procedures, including outpatient spinal procedures commonly performed on workers' compensation patients. When the OMFS is updated to implement these changes, evaluation and management visits and diagnostic procedures performed during the same outpatient episode will no longer be paid separately under the RBRVS. Since these policies will be incorporated into the next OMFS OPPS update, we estimate allowances for hospital outpatient services based on Medicare's 2016 payment policies

We use the following approach to estimate the OMFS allowances:

- For purposes of determining current payments:
    - We price services according to how they are paid (120 percent OPPS, 100 percent OPPS (in the case of facility-setting only services), RBRVS PE (non-surgical outpatient services or TC for diagnostic procedures), and laboratory tests under the Medicare fee schedule for clinical laboratory services. If a drug is not an integral part of a service that is paid under the OPPS, the OMFS rules provide that the allowance will be determined under the MediCal fee schedule. We do not determine the allowances for these drugs but rather assume the allowances equal the WCIS paid amounts. The sum of the allowances is the denominator for the impact calculation.
    - For volume counts for each service (CPT code), we include the units for services billed by hospitals in 2014 for which the paid amount >0.
- In modeling payments, we estimate the facility allowances for each hospital outpatient bill on a line-item basis. We estimate the OPPS allowances first in order to account for any services that are bundled into the OPPS payment. We then estimate the allowances for the services that are not paid under the OPPS based on the RBRVS, laboratory fee schedule, or MediCal pharmaceutical fee schedule, as applicable.
    - To estimate 2016 OPPS allowances, we apply the 2016 policy rules to determine whether line items with status code indicators = Q1, Q2, and Q3 are separately payable and to discount the units for procedures where the multiple procedure reduction applies. With few exceptions all services provided on the same hospital

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in determining the allowance for these visits. The OMFS allowance for a facility service is based on the RBRVS PE if the code is otherwise payable under the OPPS. With the new G-code, the CPT codes (which have PE RVUs) are not payable under the OPPS and the G-code that is payable under the OPPS has no PE RVUs. If bills have not been paid for this reason, the 2014 WCIS volumes may be understated.

outpatient bill for a device-intensive procedure (SI= J1) APC are included in the allowance. The allowance for items that are separately payable under the OPPS = APC relative weight x geographically adjusted conversion factor (CF) x WC multiplier x units of service. The CF ($92.47) is the 2014 CF updated for inflation and adjusted by the estimated average hospital wage index (1.35). The multiplier is dependent on the services included in the estimate. For line items that are an integral part of an ED or outpatient surgery, we use a 1.212 multiplier, which has an additional allowance for high cost outliers. For a "facility only service" we use a multiplier of 1.0101. We also use the 1.0101 multiplier to estimate what the OPPS allowances would be for services that are currently paid under the RBRVS. We find no line items for pass-through amounts (status indicator = F and H).

- To estimate RBRVS allowances, we apply the 2016 Medicare policy rules regarding bundling and multiple procedure discounting. We determine the RVUs for TC services based on the total RVUs for that component (PE + malpractice). The RVUs for the other non-OPPS that are payable under the RBRVS = the non-facility PE RVUs. We determine the allowance as the geographically adjusted RVUs x CF x 1.20 multiplier. We apply the 2016 statewide geographic adjustment factors (PE: 1.1621; MP: .7388) to the RVUs for each service. The CF ($44.186) is the 2012 Medicare rate x 1.2 ($40.8451) multiplied by the 2016 cumulative adjustment (1.0818). This is the equivalent of a fully transitioned RBRVS CF in 2016 dollars.
- To estimate CLFS allowances, we multiply the number of units by the 2016 Medicare fee schedule rates by 1.20. If there is a difference in the fee schedule rates for Northern and Southern California, we take an average of the two rates. There were some major changes in the 2016 lab fee schedule that preclude a reliable crosswalk of 2014 codes into their 2016 equivalents. For these codes, we used the 2014 allowances updated for inflation to 2016.
- To estimate allowances (MediCal) for separately paid drugs furnished during an outpatient encounter payable under the RBRVS, we use the 2014 paid amounts.

- We compare the current allowances for services paid under the RB-RVS PE or TC RVUs and the CLFS with the allowances that would be payable for comparable services at 100 percent of the OPPS allowance using 2016 payment rules. The current allowances are the sum of the separate allowances for "facility only" services, RBRVS-based allowances, CLFS allowances, and MediCal pharmaceutical allowances. Separate allowances for clinical laboratory and pharmaceuticals are not made under the OPPS; rather, these services are included in the allowance for the primary procedure.
- We determine an adjustment factor and revised multiplier so that total allowances under the OPPS would be budget neutral to current allowances. We model three alternatives for making the change budget neutral. The first would use the 1.0 multiplier for all services other than ED and surgical procedures as currently defined and make the change budget neutral to an adjustment to the 1.2 multiplier. The second would apply the same budget-neutral

multiplier to all hospital outpatient services. The third alternative would increase the multiplier for procedures that are not currently defined as surgical procedures but which are defined as surgical services under a broader definition that Medicare uses for ambulatory surgery facility services and use a 1.0 multiplier for all other services that are currently paid under RBRBS rules.

- If the new services are paid at 100 percent of Medicare:

$$Adjustment\ factor\ = 1 - \left(\frac{(1.0101\ x\ OPPS\ allowances - current\ allowances)_{current\ non-OPPS\ services}}{1.212\ OPPS\ allowances\ for\ ED\ and\ surgical\ services}\right)$$

1.212 x adjustment factor = new percent add-on to OPPS rates for ED and surgical services

- If all hospital outpatient facility fees are paid at the same multiplier:

$$Adjustment\ factor\ = 1 - \frac{(.2019\ x\ OPPS\ facility\ only\ allowances + (1.212\ x\ OPPS\ allowances - current\ allowances)_{current\ non-OPPS\ services}}{1.212\ OPPS\ allowances\ for\ all\ hospital\ HOPD\ services\ exclusive\ of\ passthroughs}$$

1.212 x adjustment factor = new percent add-on to OPPS rates for all outpatient services

Note: The 0.2019 adjustment to the OPPS allowances for services now paid at 1.0 OPPS (RBRVS "facility only" services) is the estimated increase in payments if the services were instead paid at 120 percent of the OPPS rate.

- If the services classified as surgery under an expanded definition are paid at 120 percent of Medicare and other new services are paid at 100 percent of Medicare:

$$Adjustment\ factor\ = 1 - \left(\frac{(1.0101\ x\ OPPS\ allowances - current\ allowances)_{current\ non-OPPS\ services} + .2019\ x\ OPPS\ allowances_{new\ surgery\ procs}}{1.212\ OPPS\ allowances\ for\ ED\ and\ surgical\ services\ (including\ new\ surgical\ procs)}\right)$$

Limitations

Our estimates are based on the 2014 WCIS data. Using these data has several limitations:

- Services provided during the latter part of 2014 are underreported in the data. Unless there is a systematic bias in the timeliness of data reporting, this should not have a significant impact on the adjustment factors.
- Procedures for which Medicare uses G-codes in lieu of CPT codes are inconsistently reported in the data and require us to make several pricing assumptions. See Appendix A for an explanation of how we handled several high volume codes that were reported in both CPT and HCPCS codes.

- Hospitals may now receive a facility fee for services that were previously allowed only as a physician service. The 2014 WCIS data may not fully account for services for which facility fees are allowed. An underestimate of these services would underestimate the difference between allowances under the RBRVS versus the OPPS.
- Our estimate does not take into account changes in utilization that might occur under the revised fee structure.

Findings

Completeness of the Data

Table 1 compares the 2013 and 2014 visit counts for clinic and ED visits by month. We found a sharp drop in the number of WCIS-reported visits furnished during November and December 2014. If these drops were proportional across all services, the adjustment factors should not be significantly affected. However, the reported clinic visits may be affected by the payment issues as well as the lag in data reporting.

Table 1: Clinic and ED Visits by Date of Service Reported in the WCIS

	Clinic Visits		ED visits	
	2013	2014	2013	2014
January	274	243	4,325	3,404
February	235	223	3,903	3,248
March	241	240	4,552	3,776
April	231	233	4,517	3,719
May	240	210	4,688	4,160
June	213	240	4,563	3,914
July	203	233	4,656	4,145
August	190	222	4,421	3,979
September	163	203	3,742	3,510
October	202	214	3,761	3,165
November	176	94	3,382	1,456
December	170	3	3,360	75

Total Allowances for Hospital Outpatient Services

In Table 2, Lines 1a-1g report our estimates of OMFS allowances using 2016 payment rules. Nearly 92 percent of estimated allowances for outpatient services are already determined under OPPS rules, including both the OPPS allowances for ED and surgical services and “facility-

only" services. The allowances determined under the RBRVS (Line 1d) account for 7.5 percent of estimated allowances, with the allowances determined under the CLFS and MediCal pharmaceutical fee schedule each accounting for less than 0.5 percent of allowances.

Lines 2a-2e report our estimates of OMFS allowances if the procedures currently paid under the RBRVS were paid under the OPPS using a 1.0 multiplier. Under the OPPS, separate allowances would not be made for clinical laboratory services and pharmaceuticals that are an integral part of an outpatient visit or procedure. The total allowances for the services that are paid under the RBRVS, CLFS, and MediCal fee schedule would increase 29 percent (Line 2c÷ (∑Lines 1d, 1e, 1f) - 1), resulting in an estimated 2.5 percent increase in total allowances for hospital outpatient services before consideration of budget neutrality.

Budget Neutral Multipliers Based on 2016 Medicare Policies

Table 2 also reports the estimates of the budget neutral multiplier based on 2016 Medicare OPPS policies. If the services currently paid under the RBRVS PE were instead paid at 1.0 x the OPPS rate, the budget neutral multiplier for surgery and ED services would be 1.179 (Line 3e). If instead all hospital outpatient services were paid using the same multiplier, we estimate the budget neutral multiplier applicable to all services would be 1.157 (Line 4f). Raising the multiplier only for the services currently paid under the RBRVS that meet the expanded definition of surgery would result in a 1.178 multiplier for surgery and surgical services (Line 5f). This is the definition of surgery that Medicare uses for purposes of deciding what services are eligible for an ASC facility fee. It includes both some temporary CPT codes, G-codes are comparable to a CPT surgical code, and invasive cardiology procedures.

Discussion

A single multiplier is less complicated to implement and avoids any unanticipated issues associated with having two multipliers. For ED and surgical services, there is a relatively small difference between the adjustment factors that would apply using a single or two multipliers so that using a single multiplier has a relatively small effect on payment for these services. However, there is significant increase in the allowances for the other services using the 1.0 multiplier – and even more so using the 1.2 multiplier. Because the 1. 0 multiplier provides a lower increase for radiology services, it is less likely to raise issues about the disparity in payments between hospitals and office-based radiology services. On the surface, it would be relatively easy to implement: ED and surgical services and services that are integral to those services would have an add-on and all other services would be paid at 100 percent of the Medicare OPPS allowances.

As discussed above, there are a number of data limitations to our analyses. By choosing 2014, we limit the need to crosswalk outdated CPT codes, but the payment systems were in transition and may not reflect future billing patterns. Given the uncertainties and the likelihood of

increasing complexities as more comprehensive APCs are implemented. These analyses are our best estimate of the budget neutral adjustment. We believe that reexamining the adjustment factors after several years of experience under whatever policies are implemented is not a realistic option. There will always be uncertainties in making the comparisons because the code sets used under the RBRVS and the OPPS are not identical and the relative weights and APCs are revised on an on-going basis. For example, to the extent clinic visits are billed under a single G-code under the OPPS, the ability to estimate what would have been payable using the CPT codes under the RBRVS will be lost. If a re-estimation option is provided, consideration should be given to making it a one-time correction and only if the estimation error exceeds an established threshold.

Table 2: Comparison 2016 Allowances under Current Policies to OPPS Allowances and Estimated Budget Neutral Adjustment Factors ($, 000s)

1. Allowances under Current Policies (based on RAND analysis of 2014 WCIS)	
a. OPPS allowances for ED and surgical services (1.212 multiplier)	76,279.5
b. OPPS allowances for "Facility Only Services" (1.0101 multiplier)	401.2
c. Paid amounts for OPPS pass-through services	.0
d. RBRVS allowances based on PE or TC RVUs	6,298.9
e. Clinical laboratory fee schedule allowances	416.5
f. MediCal allowances for pharmaceuticals	318.5
g. Total estimated allowances under current policies (Sum of lines 1a-1f)	83,714.6
2. Allowances if Services Currently Paid Under the RBRVS Were Paid 1.0 x OPPS (Before Adjustment)	
a. OPPS allowances for ED and surgical services (Line 1a)	76,279.5
b. OPPS allowances for "facility-only" services (Line 1b)	401.2
c. OPPS allowances for current non-OPPS services (1.0 101 multiplier; RAND estimate)	9,091.5
d. Paid amounts for OPPS pass-through codes (RAND estimate)	.0
e. Total Estimated Allowances under OPPS (Sum of Lines 2a-2d)	85,772.2
f. Total increase in estimated allowances (Line 2e-line 1g)	2,057.5
Percent increase in total estimated allowances (Line 2f÷Line 1g)	2.5%
3. Adjustment to Multiplier for Surgery/ED to allowances budget neutral	
a. Estimated difference in allowances (Line 2f)	2,057.5
b. Estimated OPPS allowances for ED and surgical services (Line 2a)	7,6279.5
c. Difference as a percent of ED/surgical service allowances (Line 3a÷Line 3b)	2.7%
d. Adjustment factor for ED/surgical services (1-Line 3c)	97.3%
e. Revised multiplier for ED/surgical services (1.212 x Line 3d)	1.179
4. Adjustment if same multiplier applied to all services	
a. Estimated increase for moving to OPPS at 1.0 multiplier(Line 3a)	2,057.5
b. Additional increase for moving to 1.2 multiplier (0.2019 x (Line 2b + line2c))	1,916.6
c. Total increase in estimated allowances (Line4a+line 4b)	3,974.1
d. Differences as a percent of total estimated allowances (Line 4c/(Line 2a +1.2(Line 2b+2c)))	4.5%
e. Adjustment factor (to be applied to 1.2 multiplier; 1-line 4d)	95.5%
f. Revised multiplier for all services paid under OPPS (1.212 x Line 4e)	1.157

5. Adjustment if only expanded surgery is increased to 1.2 multiplier		
a.	Estimated increase for moving to OPPS at 1.0 multiplier(Line 3a)	2,057.5
b.	Estimated OPPS payments for expanded surgery definition (RAND estimate)	92.6
c.	Total increase in estimated allowances (Line 5a + Line 5b)	2,150.2
d.	Differences as a percent of total estimated allowances for services paid at 1.2 (Line 5b/(Line 2a +line 5b))	2.8%
e.	Adjustment factor (to be applied to 1.2 multiplier; 1-line 5d)	97.2%
f.	Revised multiplier for all services paid under OPPS (1.212 x Line 5e)	1.178

APPENDIX A PROCEDURES BILLED UNDER BOTH CPT AND HCPCS CODES

For some procedures, Medicare has implemented an alpha-numeric HCPCS code to pay for the procedures either under the OPPS only or under both the OPPS and the RBRVS. In the WCIS 2014 data for these procedures, we found that a mix of the relevant CPT codes and the alpha-numeric codes were used to report the services. Below, we explain how we estimated allowances for these services.

Billing Facility Fees for Clinic and Observation Visits

The WCIS data for clinic visits is particularly problematic. Medicare replaced the CPT clinic visit codes (99201-99205 (new patient visit), 99211-99215 (established patient visit)) with a single G-code for outpatient clinic visits (G0463) in 2014. For physician services, the CPT codes continue to apply. Throughout 2014, we find clinic visits reported using both CPT codes and the G0463 code. For estimation purposes, we assume that the RBRVS allowance for services billed using the G0463 code is the same as the average allowance for visits billed using the CPT codes. Further, we assume that the OPPS allowance for services billed using the CPT codes would be the same as the allowance for G0463.

Observation visits were also reported using both CPT codes (99218-99226) and G-codes throughout 2014. Because these are "facility only services", the allowances for these services should be based on 100 percent of the OPPS rate. There are two observation codes:

1. G0378 was bundled in 2016 and did not have a separate payment rate.
2. G0379 (Direct referral for observation) is payable under the OPPS and has a Q3 indicator that results in potential assignment to a composite APC.

We cannot crosswalk the CPT codes into the two G-codes because the CPT codes do not distinguish between direct referrals for observation and other observation care. For estimation purposes, we assume that the average allowance for the two G-codes would apply to the observation care that was billed using the CPT codes. Because less than one percent of the observation care reported using G-codes was for direct referrals, nearly all observation services are bundled and the estimated average payment for these services is negligible in 2016. However, the presence of the G0378 code affects the 2016 assignment to C-APC 8011.

Other Services Billed Using Both CPT and HCPCS Code Services

We reviewed the line items that did not match the OPPS Addendum B to identify other CPT codes with SI=B to ascertain whether there was a corresponding alpha-numeric HCPCS code. This resulted in the line items for the following services reported with CPT codes being assigned to an alpha-numeric code:

i. OPPS and RBRVS
   CPT 27096=G0260

ii. OPPS only
73225 =C8936
73725=C8914
74185=C8902