CY 2011 Changes to the Hospital OPPS

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The final rule for the calendar year 2011 Hospital Outpatient Prospective Payment System (OPPS) was released November 24, 2010. Changes in the rule went into effect with January 1, 2011, outpatient hospital-based services.

The changes to OPPS continue to reflect packaging adjustments and refinement of preventive services as well as other financial adjustments mandated by provisions of the Affordable Care Act. In addition, this year there are significant changes to CPT codes representing revascularization and cardiac catheterization procedures.

Financial Impact for CY 2011

The Centers for Medicare and Medicaid Services (CMS) finalized the conversion factor for OPPS after considering the market basket update figures of 2.6 percent and adjusting it to be consistent with the mandated 0.25 percent reduction required by elements of the Affordable Care Act. The finalized adjustment factor was calculated as a 2.35 percent increase based on the outpatient department fee schedule.

The result for hospitals that successfully report quality data will be a conversion factor of $68.876. For the few hospitals that either do not report quality data or are unable to successfully do so, the conversion factor for CY 2011 will be $67.530.

Visit Reporting Guidelines

CMS continues to review the need to establish national guidelines for the coding and reporting of clinic and emergency department hospital visits. CMS has observed a normal and stable distribution of clinic and emergency department visit levels in hospital claims over the last several years. Based on this data consistency, there is currently no proposal to implement national visit guidelines prior to CY 2012.

Inpatient-Only Procedures

CMS continues to evaluate inpatient-only procedures and as a result of public recommendations and data analysis has determined that it is appropriate to remove three procedures from the inpatient-only procedure list for CY 2011. CPT codes 21193 and 21395 were assigned to APC 256, and CPT code 25909 was assigned to APC 49.

All three procedures were assigned a status indicator of "T" indicating they are subject to multiple procedure payment reductions:

- 21193, Reconstruction of mandibular rami; horizontal, vertical, C, or L osteotomy; without bone graft
- 21395, Open treatment of orbital blowout fracture; periorbital approach with bone graft (includes obtaining graft)
- 25909, Amputation, forearm, through radius and ulna; reamputation

New HCPCS Modifier

A provision in the Affordable Care Act waives deductibles for colorectal cancer screening tests furnished in connection with, as a result of, and in the same clinical encounter as a screening test regardless of the code billed. As a result, CMS is waiving the deductible for all surgical services furnished on the same date as a planned screening colonoscopy, planned flexible sigmoidoscopy, or barium enema as being furnished in connection with, as a result of, and in the same clinical encounter as the screening test.

Modifier "PT" must now be appended to the diagnostic procedure code that is reported instead of the screening colonoscopy or screening flexible sigmoidoscopy HCPCS code or as a result of the barium enema when the screening test becomes a diagnostic service.

Payment Status Indicators

There are no changes to the status indicator list for CY 2011. The list, as approved for CY 2010, will remain in effect for CY 2011.

Supervision of Hospital Outpatient Diagnostic and Therapeutic Services

CMS required physician supervision of diagnostic and therapeutic services provided to hospital outpatient incidents in the CY 2000 OPPS final rule. CMS adopted this as a condition of payment to ensure that Medicare pays for high-quality hospital outpatient services provided to beneficiaries in a safe and effective manner consistent with Medicare requirements.

CMS clarified and restated the payment requirements for physician supervision of hospital outpatient therapeutic and diagnostic services beginning with the CY 2009 rules, and it further delineated the guidance in the CY 2010 rules. The large number of comments it received in response has prompted CMS to address this issue once again.

In manual guidance, CMS notes that it expects outpatient services to be performed under direct supervision. The previous definition of direct supervision required that the physician be "physically present on-site" and "immediately available to furnish assistance and direction throughout the performance of the procedure; however, the physician does not have to be present in the same room when the procedure is being performed."

The new definition states:

> For services furnished in the hospital or Critical Access Hospital (CAH) or in an outpatient department of the hospital or CAH, both on- and off-campus… "direct supervision" means that the physician or nonphysician practitioner must be immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician or nonphysician practitioner must be present in the room when the procedure is performed. For pulmonary rehabilitation, cardiac rehabilitation, and intensive cardiac rehabilitation services, direct supervision must be furnished by a doctor of medicine or osteopathy.

Acknowledging the challenges critical access and rural hospitals face in meeting this new definition, CMS is extending its existing notice of nonenforcement to critical access and small rural hospitals with 100 or fewer beds through CY 2011. These facilities will be required to comply with the physician supervision mandates effective with CY 2012.

Device-Dependent APCs

The new rule includes minor adjustments to the list of device-dependent APCs for CY 2011, due in some part to the creation of new endovascular revascularization codes in CPT.

These new CPT codes (37220–37235) have been assigned to APCs 83, 229, and new 319, Endovascular Revascularization of the Lower Extremity.

Another new APC in the device-dependent APCs category is 318, Implantation of Cranial Neurostimulator Pulse Generator and Electrode.

New Technology APCs

CMS has the option to keep a procedure in the new technology APC grouping until sufficient data have been accumulated to allow the appropriate reassignment into a clinical APC group. The accumulation of these data may be affected by an original assignment that was based on inaccurate or inadequate information, although the information may have been the best information available at the time of the original assignment. Of the four services described by G codes, only one of them is being assigned to the clinical APC group for CY 2011.

Code G0416, Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 1–20 specimens, is now assigned to clinical APC 0661 (level V pathology).

Code G0417, Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 21–40 specimens, which was originally assigned to APC 1507, has been reassigned within the new technology APCs to APC 1506 as a result of median cost adjustments.

The two remaining G codes-G0148 and G0419-will continue in their current new technology APC assignments for CY 2011.

Hospital Outpatient Quality Data Reporting

Annual payment updates are affected by hospital compliance with the Hospital Outpatient Quality Data Reporting program implemented for services furnished by hospitals in outpatient settings on or after January 1, 2009. Current mandates require a 2 percent reduction to annual payment update factors for facilities that do not comply with the reporting requirements.

Currently there are 11 measures used in annual payment determination. These measures will continue for CY 2011. Seven of the measures are chart-abstracted measurements that are measured in three inpatient settings: AMI, cardiac care, and surgical care. The four remaining measures address imaging efficiency in hospital outpatient departments.

The measures for payment in CY 2011are:

- OP–1: Median Time to Fibrinolysis
- OP–2: Fibrinolytic Therapy Received within 30 Minutes
- OP–3: Median Time to Transfer to Another Facility for Acute Coronary Intervention
- OP–4: Aspirin at Arrival
- OP–5: Median Time to ECG
- OP–6: Timing of Antibiotic Prophylaxis
- OP–7: Prophylactic Antibiotic Selection for Surgical Patients
- OP–8: MRI Lumbar Spine for Low Back Pain
- OP–9: Mammography Follow-up Rates
- OP–10: Abdomen CT-Use of Contrast Material
- OP–11: Thorax CT-Use of Contrast Material

CMS is actively seeking alternatives to manual chart abstraction for the collection of quality measures for the quality reporting programs. Among the alternative measures it is considering are claims-based measure calculations, collection of data from systematic registries widely used by hospitals, and electronic submission of quality measures using electronic health records. CMS continues to work with the HIT Standards Committee and the HIT Policy Committee on the standardization of specifications that will allow software to convert clinical data into a form that can be analyzed for quality measurement.

Reference

Centers for Medicare and Medicaid Services. "Medicare Program: Hospital Outpatient Prospective Payment System and CY 2011 Payment Rates; Ambulatory Surgical Center Payment System and CY 2011 Payment Rates; Payments to Hospitals for Graduate Medical Education Costs; Physician Self-Referral Rules and Related Changes to Provider Agreement Regulations; Payment for Certified Registered Nurse Anesthetist Services Furnished in Rural Hospitals and Critical Access Hospitals; Final Rule." *Federal Register* 75, no. 226 (Nov. 24, 2010). Available online at http://edocket.access.gpo.gov/2010/pdf/2010-27926.pdf.

Additional Coding and Reimbursement Resources

AHIMA offers other coding and reimbursement resources for coding professionals, including:

- *CodeWrite*, a monthly e-newsletter exclusively created for coding professionals from the Coding Community of Practice

- *E-Alert*, for news affecting the profession
- *ICD-TEN*, a monthly e-newsletter exclusively created to assist the industry in the current transition from ICD-9-CM to ICD-10-CM and ICD-10-PCS code sets
- Coding Community of Practice
- *Journal* Web site, http://journal.ahima.org
- AHIMA Body of Knowledge
- Audio seminars, books, and in-person events

For more information on these resources, visit www.ahima.org.

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