Key Issues in the 2008 OPPS Final Rule

by Andrea Clark, RHIA, CCS, CPC-H

The main objective of the Centers for Medicare and Medicaid Services (CMS) implementation of the 2008 Outpatient Prospective Payment System (OPPS) final rule was to address the recent explosion of growth in program expenditures for hospital outpatient services. CMS has created additional incentives for hospitals to provide only necessary services in the most efficient manner. As a result of these revisions, hospitals must develop strategies for analyzing the financial impact and operational challenges by reviewing the following key issues in the final rule.

1. Expanded Packaging Concept

As an initial step toward creating larger payment groups for hospital care, CMS has packaged payment for items and services in certain categories of HCPCS codes. Table 10 in the final rule (page 66659) contains a complete list of all codes in the final seven categories. Finalized packaged services include guidance, image processing, intraoperative services, imaging supervision, interpretation, diagnostic radiopharmaceuticals and contrast agents, and observation services. CMS will package payment either unconditionally (status indicator (SI) N) or conditionally, allowing separate payment if certain criteria are met (SI Q). (The difference in payment for unconditionally and conditionally packaged services are shown in the table "2008 Unconditionally and Conditionally Packaged Services," below.)

The Outpatient Code Editor will determine SI Q with two trigger levels. For level 1, if SI Q is reported on the same day as SI S, T, V, or X, payment for Q will be packaged. For level 2, payment for Q will be packaged if SI Q is reported on the same date as SI T.

Hospitals should continue to report all appropriate codes and charges for all services furnished, packaged or not. CMS emphasizes that there are no new billing requirements associated with this change in policy payment.

2. Composite APC for Observation

For calendar year 2008, payment for observation care is packaged as part of the payment for the separately payable services with which it is billed. CMS created composite APC (CAPC) for observation services, both direct admission and emergency department (ED), eliminating specific diagnosis requirements. CMS has also updated the conditions that must be met for CAPC. If not met, the observation will be packaged.

Two CAPCs will provide payment to hospitals in certain circumstances when extended assessment and management of a patient occur. CAPC 8002 (Level I Extended Assessment and Management Composite) is synonymous with direct admission observation from a clinic or physician office. CAPC 8002 will be assigned when eight or more units of HCPCS code G0378 are billed on the same day as G0379 or on the day after 99205 or 99215.

If SI T is present on the same date of service or one day earlier, separate observation payment will not be generated; payment for any separately payable services including the clinic or G0379 will be made through the usual associated APCs. (The difference in payment for a composite observation 8002 is shown in "Composite Observation 8002 Example," below.)

CAPC 8003 (Level II Extended Assessment and Management Composite) will be assigned when eight or more units of code G0378 are billed on the same day or the day after code 99284, 99285, or 99291. If SI T is present on the same date of service or one day earlier, separate observation payment will not be generated; payment for any separately payable services including the ED E/M will be made through the usual associated APCs. (The differences in payment for composite observations 8003 are shown in the tables below.)

It is vital for hospitals to review their current observation operational process and compare this new payment policy.

2008 Unconditionally and Conditionally Packaged Services

Unconditionally Packaged Mammotone Vacuum Rotation Biopsy									
			2007			2008			
Rev Code	CPT/HCPCS	Description	SI	APC	Payment Rate	SI	APC	Payment Rate	Impact
0361	19103-LT	Bx breast percut w/device	T	0658	$395.77	T	0037	$864.74	
0361	19295-LT	Place breast clip, percut	S	0657	$106.76	N		–	
0402	76942	Echo guide for biopsy	S	0268	$73.04	N		–	
					$575.57			$864.74	$289.17
Conditionally Packaged Percutaneous AV/Fistula Ballooning									
0320	75978	Repair venous blockage	S	0668	$383.95	Q	0083	–	
0320	75790	Visualize A-V shunt	S	0279	$584.32	Q	0668	–	
0361	36145	Artery to vein shunt	N		–	N		–	
0361	36145–59	Artery to vein shunt	N		–	N		–	
0361	G0393	AV fistula or graft venous	T	0081	$2,639.19	T	0083	$2,890.72	
					$3,607.46			$2,890.72	($716.74)

Composite Observation 8002 Example

Level I Direct Observation									
A patient is seen in a physician's office for dehydration and UTI. The hospital is informed, and patient presents for direct observation at 1 p.m. The patient is discharged at 5 p.m. the next day.									
			2007			2008			
Rev Code	CPT/HCPCS	Description	SI	APC	Payment Rate	SI	APC	Payment Rate	Impact
0760	90760	Hydration IV infusion, init (1 unit)	S	0440	$111.20	S	0440	$114.64	
0760	90761	Hydration IV infusion, add-on (8 units)	S	0437	$194	S	0437	$201.04	
0762	G0378	Hospital observation per hr (16 units)	N		–	N		–	
0762	G0379	Direct admit hospital observ (1 unit)	Q	0604	$50.66	Q	8002	$351.04	
					$355.86			$666.72	$310.86

3. Injections and Infusions

Hospitals should continue to use the CPT codes, definitions, and guidelines as listed in the current CPT Manual. Coders should pay close attention to 2008 CPT updates that include drug hierarchy rules for facility reporting.

Code 90776 should be reported for the use of each additional sequential intravenous push of the same substance or drug provided in a facility. Code 90760 has been revised to 31 minutes to one hour. CPT codes 90776 and 90768 are packaged payments, or SI N. These codes are time-based and require timeline documentation in order to support charge capture and APC revenue reimbursement.

4. E/M Levels under OPPS

National guidelines have not been implemented for calendar year 2008, therefore, hospitals should continue to use their internally developed guidelines to determine the appropriate reporting of different levels of clinic and ED visits. In addition,

internal guidelines should adhere to the 11 principles developed by CMS. Hospitals should review the principles and perform detailed audits with staff on E/M criteria to maintain compliance.

The final rule reiterated that type A and B ED visits will continue with no changes to the definitions. CPT codes 99241–99245 will be changed to SI B, which cannot be reported for bill type 131.

Composite Observation 8003 Examples

Level II Observation with Chest Pain, Asthma, and CHF									
A patient presents to ED at 7 a.m. with chest pain and other chronic conditions including history of CVA. Observation is ordered at 10 a.m. along with additional tests. Patient is discharged the next day by 12 p.m.									
			2007			2008			
Rev Code	CPT/HCPCS	Description	SI	APC	Payment Rate	SI	APC	Payment Rate	Impact
0320	75671	Artery x-rays, head and neck	S	0280	$1,279.92	Q	0280	$2,847.85	
0361	36100	Establish access to artery	N		–	N		–	
0450	99284-25	Emergency dept visit	V	0615	$209.99	Q	8003	$638.66	
0450	90760	Hydration IV infusion, init (1 unit)	S	0440	$111.20	S	0440	$114.64	
0760	90761	Hydrate IV infusion, add-on (1 unit)	S	0437	$24.25	S	0437	$25.13	
0762	G0378	Hospital observation per hr (14 units)	Q	0339	$442.81	N		–	
					$2,068.17			$3,626.28	$1,558.11

		OSBV2007 (Plus E/M)	$652.80	OBSV 2008 (includes E/M)	$638.66	

Level II Observation without Chest Pain, Asthma, and CHF

A patient presents to ED from a nursing home with a head laceration at 9 p.m. The patient has chronic conditions—Alzheimer's, diabetes, and urinary incontinence. The patient is admitted to observation at 1 a.m. and discharged at 5 p.m.

			2007			2008			
Rev Code	CPT/HCPCS	Description	SI	APC	Payment Rate	SI	APC	Payment Rate	Impact
0320	70470	CT head/brain w/o & w/dye	S	0333	$297.54	S	0333	$325.64	
0450	12034	Layer closer of wound(s)	T	0024	$91.24	T	0134	$134.08	
0450	51702	Insert temp bladder cath	X	0340	$37.51	X	0340	$40.19	
0450	90760	Hydration IV infusion, init	S	0440	$111.20	S	0440	$114.64	
0450	90761	Hydrate IV infusion, add-on	S	0437	$24.25	S	0437	$25.13	
0450	99284-25	Emergency dept visit	V	0615	$209.99	V	0615	$212.59	
0636	Q9947	LOCM 200–249mg/ml iodine, 1 ml (150 units)	K	9159	$216.00	D		–	
0762	G0378	Hospital observation per hr (16 units)	Q		–	N		–	

					$987.73			$852.27	$135.46
		OBSV 2007 – Packaged				OBSV 2008 – Packaged			

5. Device-dependent Discounting under OPPS

CMS has continued its policy on reducing the APC amount to a hospital if the device is received at no charge or a full-credit warranty replacement is reported with modifier –FB. Modifier –FC was created for partial credit and device upgrade, if the device is replaced with partial credit from the manufacturer that is equal to or greater than 50 percent of the cost of the replacement device. Hospitals should review tables 25 and 27 in the final rule carefully with the operating room staff and develop a method of communication when this occurs.

6. Migration of APC Payments for 2008

By law, CMS must annually review APC groups and recalibrate where necessary, especially when the two-times rule is violated. Hospitals should focus on the following areas of interest to evaluate the coding and financial impact for 2008:

- Cardiac CT and CTA (APCs 0282, 0383). Hospitals will experience a decrease in APC revenue with ever- increasing detailed requirements for local and national coverage determinations.
- Shoulder arthroscopy (APCs 0041, 0042). This is one of the top 25 procedures performed in an ambulatory surgery setting and is receiving a bump in APC revenue equating to $1,000. Hospitals should invest in dedicated audits of ambulatory surgery procedures to ensure correct code and modifier reporting along with reliable claims submission.
- Intradiscal annuloplasty and Kyphoplasty (APCs 0050, 0052). Hospitals will experience an APC revenue increase; however, imaging performed in conjunction with these procedures will now be packaged.
- Skin repair procedures (new APCs 0133, 0134, 0135, 0136, 0137). Hospitals should conduct audits on simple, intermediate, and complex repairs to ensure sufficient documentation and APC revenue integrity.
- Coronary and noncoronary angioplasty (APCs 0082, 0083, 0103). Deletion of APC 0081 and movement of codes to APC 0083 will have a financial impact for all facilities.

Hospitals should perform a financial analysis by comparing medical records with claims from 2007–2008 payments and communicate the results to the appropriate departments.

7. Updates to Pharmacy Charge Description Master

In calendar year 2008, Medicare will reimburse drugs using average sales price plus 5 percent, which has integrated payments for both acquisition and overhead costs aggregate. The threshold for packaged drugs is less than $60. Anti-emetics remain exempt from the packaging requirement, along with intravenous immunoglobulin pre-administration reported with HCPCS code G0332.

CMS is also going to allow hospitals to report any HCPCS code for a Part B drug that is covered under OPPS, regardless of the unit determination in the HCPCS descriptor. Table 34 in the final rule lists previously unrecognized codes by moving the SI from B to K. Brachytherapy sources cost-based reimbursement will end, and beginning in 2008, these will be paid via separate APC payment rates based on 2006 claims median cost data. CMS will continue to pay for transitional pass through drugs (SI G), separately payable drugs without pass through payments (SI K), vaccines (SI L, F), and orphan drugs (G).

Hospitals should review addendum B to sort through the above-mentioned status indicators in order to assist with the charge description master update and use the 2008 HCPCS book for the long descriptors and dosage. Pharmacy systems typically have “sub-basements” that must be mapped to the charge description master in order for the HCPCS code to transfer to the UB-04 claim form. Recheck the revenue codes and validate a sample of claims quarterly to ensure APC revenue integrity for appropriate HCPCS code(s) and units.

8. Other CAPC Payments

Three new CAPCs have been added. CAPC 8000, Cardiac EPS and ablation, is triggered by one CPT code for the evaluation (93619 or 93620) and one CPT code for the ablation (93650, 93651, or 93652). CAPC 8001, LDR prostate brachytherapy, is triggered by CPT codes 55875 and 77778, respectively, on the same claim. CAPC 0034, Mental health, which was previously considered per diem, has now been moved to composite.

9. Hospital Outpatient Quality Data Reporting Program

CMS introduced seven outpatient measures that will tie to future OPPS payments. Hospitals not wishing to participate or that withdraw from the program will not receive the full OPPS payment rate update. These hospitals will receive a reduction of 2 percentage points in their updates for the affected payment year 2009. Hospitals exempt from IPPS and critical access hospitals are exempt from this provision.

Hospitals are required to begin reporting data in 2008 in order to get the 2 percent 2009 payment update, but CMS will not apply any validation criteria to the submitted data. The validation has been postponed, and CMS intends to begin applying it in 2010.

10. APC Financial Barometer

Under OPPS, CMS annually updates the financial indicators that include outlier formulas, the conversion factor, and cobeneficiary payments. For hospitals, the outlier formula changed this year. Outlier payments are triggered when the cost of furnishing a service or procedure by a hospital exceeds 1.75 times the APC payment amount and exceeds the APC payment rate plus $1,575 (as opposed to $1,825 in 2007). The outlier payment remains at 50 percent of the amount by which the cost is exceeded.

The national conversion factor for 2008 is $63.694. The beneficiary copayment is 40 percent of the APC payment, and the minimum remains 20 percent. Hospitals in rural areas with no more than 100 beds will continue to receive an applicable percentage of outpatient reimbursement under the Deficit Reduction Act of 2005. In addition, rural sole community hospitals and essential access community hospitals will continue to receive a 7.1 percent payment increase in 2008.

For an analysis of the 2008 revisions to the Medicare Hospital Outpatient Prospective System, visit www.ahima.org/dc/documents/MicrosoftWord-OP-PPSanalysis_CY08.pdf. To read the final changes on the CMS Web site, go to www.cms.hhs.gov/HospitalOutpatientPPS/HORD/list.asp#TopOfPage and follow the links provided for 2008.

Andrea Clark (aclark@healthrevenue.com) is president of Health Revenue Assurance Associates.

Article citation:
Clark, Andrea. "Key Issues in the 2008 OPPS Final Rule" *Journal of AHIMA* 79, no.3 (March 2008): 76-79.