Key Issues in the 2009 OPPS Final Rule

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The final rule for the 2009 Outpatient Prospective Payment System (OPPS) includes multiple revisions that hospitals must address in their practices, policies, and operations. Hospitals should develop strategies for analyzing the financial impact and operational challenges by reviewing the following key issues in the final rule.

APC Financial Barometer

Under OPPS, the Centers for Medicare and Medicaid Services (CMS) annually updates the financial indicators that include the conversion factor, cobeneficiary payments, and outlier formulas. Since the reimbursement landscape evolves year to year it is imperative to stay on top of these changes.

Outlier payments for 2009 are triggered when the hospital's cost of furnishing a service or procedure exceeds 1.75 times the APC payment amount and exceeds the APC payment rate plus $1,800 (up from $1,575 in 2008). The outlier payment remains at 50 percent of the amount by which the cost is exceeded.

The national conversion factor for 2009 is $66.059. For hospitals that do not meet the hospital outpatient quality data reporting program requirements, the conversion factor is reduced by 2 percent, or $64.784. The beneficiary copayment is 40 percent of APC payment, and the minimum remains 20 percent.

Rural sole community hospitals and essential access community hospitals will continue to receive a 7.1 percent payment increase in 2009. They are also eligible for the transitional pass through payments or 85 percent of the difference between what the OPPS payment is and the previous cost-based system continuing through January 1, 2010.

Hospitals in rural areas with no more than 100 beds will continue to receive transitional pass through payments if applicable. It is essential to educate physicians on the inpatient procedure only list changes.

Pharmacy Charge Description Master

For 2009 Medicare will reimburse drugs using average sales price plus 4 percent, which has integrated payments for both acquisition and overhead costs aggregate. The threshold for packaged drugs is median cost less than $60. Antiemetics remain exempt from the packaging requirement. HCPCS code G0332 will be deleted for 2009 due to the improvement of IVIG drug access.

The previous payment was a temporary measure during a period of market instability. The Medicare Improvements for Patients and Providers Act of 2008 provides provisions for therapeutic radiopharmaceuticals and brachytherapy sources, which will continue with cost-based reimbursement through December 31, 2009.

E/M Levels under OPPS

Hospitals must continue to use their internally developed guidelines for emergency department and clinic E/M visits and adhere to the 11 reporting principles CMS developed in 2008. However, the definition for determining new versus established facility E/M levels has changed for 2009.

The previous definition on whether a patient has had a medical record number created within the past three years has been modified to whether or not the patient has been registered as an inpatient or outpatient of the hospital. A patient who has been registered as an inpatient or outpatient of the hospital within three years prior to the visit is now considered to be an established

patient for a visit, and a patient who has not been registered as an inpatient or outpatient of the hospital within three years prior to the visit is now considered to be a new patient for that visit.

Hospitals should perform detailed audits in all areas that report E/M levels to ensure consistency and accuracy and incorporate the clinic definition of new versus established facility E/M levels. Monitoring use of modifier 25, especially for those clinics in which scheduled procedures are performed with a medical visit on the same day, helps zero in on where Recovery Audit Contractors will be focusing their attention. The final rule reiterated that type A and B ED visits will continue with no changes to the definitions.

Fiscal intermediaries and Medicare administrator contractors have requested clarification regarding CMS's policy regarding facility claims and the submission of critical care services reported with CPT code 99291 from December 2007 through 2008. The question is whether the CPT instructional guidelines within the critical care section of the CPT manual and the services that are included pertain to hospitals. The 2009 OPPS final rule clarifies CMS's position, stating:

> Hospitals should separately report all HCPCS codes in accordance with correct coding principles, CPT code descriptions, and any additional CMS guidance, when available. Specifically with respect to CPT code 99291, hospitals must follow the CPT instructions related to reporting that CPT code. Any services that CPT indicates are included in the reporting of CPT code 99291 should not be billed separately by the hospital. In establishing payment rates for visits, CMS packages the costs of certain items and services separately reported by HCPCS codes into payment for visits according to the standard OPPS methodology for packaging costs.[1]

Drug Administration Services

Providers should continue to use CPT codes, definitions, and guidelines for drug administration services as listed in the CPT manual. The American Medical Association deleted CPT codes 90760–90779 and renumbered them for proximity to the chemotherapy and other complex infusion services reported with 96401–96549.

This was CMS's first opportunity to examine hospitals' 2007 claims data for the full set of CPT codes reflecting concepts for initial, sequential, and concurrent services. For 2009, CMS collapsed the current six drug administration APCs into five, which will have a financial impact both at the APC and CPT level (see table 34 in the final rule).

Coding professionals should instruct clinicians that these are time-based codes that require time-line documentation in order to support charge capture and APC revenue reimbursement.

Relocation of APC Payments

By law, CMS must annually review APC groups and recalibrate where necessary, especially when the two-times rule is violated. Organizations should perform a financial analysis by comparing 2008–2009 payments and communicate the results to the appropriate departments. The best way to accomplish this task is to perform an audit of the medical record documentation and claims submissions.

HOP QDRP

CMS introduced seven outpatient measures in 2008 to tie to future OPPS payments. For 2009, four new measures have been added and include MRI lumbar spine for low back pain, mammography follow-up rates, abdomen CT use of contrast material, and thorax CT use of contrast material. CMS stated adoption of these four imaging efficiency measures into the HOP QDRP is appropriate for measurement of quality of care furnished by hospitals in outpatient settings.

Hospitals that failed to report quality measure data in 2008 will begin to see a 2 percent reduction in their 2009 conversion factor. This means hospitals will be paid at a lower APC payment rate than those providers who met the reporting requirements. Beneficiary and secondary payer payments will also be reduced. Hospitals that are exempt from IPPS are also exempt from these provisions as are critical access hospitals.

Expanding APC Composites—Imaging Families

Composite APCs were developed to provide a single payment for two or more services that are typically performed together during a single clinical encounter that results in the provision of a complete service. Composite APCs are intended to expand the OPPS payment bundles and encourage hospital efficiencies. The newest member of the family is imaging.

CMS created and finalized five new composite APCs: 8004, ultrasound; 8005, CT/CTA without contrast; 8006, CT/CTA with contrast; 8007, MRI/MRA without contrast; and 8008, MRI/MRA with contrast. Coding professionals should review table 8 in the OPPS final rule to identify the imaging families and CPT codes that are affected and evaluate the ordering frequency of pair families for outpatient services during calendar year 2008. Coding professionals should also compare standard APC payments versus composite rate, remembering the composite rate includes all resources (i.e., contrast media).

One composite APC payment will be made when more than one HCPCS code from the same imaging family is provided on the same date of service. If a procedure without contrast is performed during the same session (same date of service) and at least one other procedure with contrast in the same family imaging modality, the hospital will receive payment for the "with contrast" composite only. An imaging procedure performed from different imaging families will be paid according to the standard OPPS methodology rather than composite.

Established Composite APCs Continue for 2009

APC composite payments (8000, Cardiac electrophysiologic evaluation and ablation; 8001, Low dose rate prostate brachytherapy; 8002, Level 1 extended assessment and management; 8003, Level II extended assessment and management; and 0034, mental health) will continue for 2009. There are no major changes to the above composite APCs except for the inclusion of HCPCS G0384, Level 5 type B ED, in the criteria for composite APC 8003. CMS intends to expand and explore where this payment model may be used in the future to further encourage hospital efficiency.

Note

1. Centers for Medicare and Medicaid Services. "Hospital Outpatient PPS Final Rule." *Federal Register,* November 18, 2008. Available online at http://edocket.access.gpo.gov/2008/pdf/E8-26212.pdf.

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