

Final Rule 2008 OPPS-Highlights



Presented by Karen G. Youmans, MPA, RHIA, CCS
For United Audit Systems, Inc. (UASI)
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Timeline of Updates

- April 7, 2000 final rule published in Federal Register (65 FR 18434) which established requirements for The Outpatient Prospective Payment System (OPPS)
- The OPPS was first implemented for services provided on or after August 1, 2000.
- Since that time a number of rule-making changes have occurred

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Timeline of Updates -- 2008

- On August 2, 2007, the proposed rule for OPPS CY 2008 was issued in the Federal Register (72 FR 42628)
- The CY 2008 OPPS Final rule was published on CMS website (CMS-1392-FC) on November 1, 2007
- Final rule published in the November 27, 2007 Federal Register which outlines the OPPS changes for CY 2008 (72 FR 66579)

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Addendum A - B

- Addendum A--OPPS APCs for CY 2008
- Addendum AA--ASC Covered Surgical Procedures for CY 2008 (Including Surgical Procedures for Which Payment is Packaged)
- Addendum B--OPPS Payment By HCPCS Code for CY 2008

Note: Co-payment amounts for each APC may be found in Addendum A & B.

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Addendum BB – DD2

- Addendum BB--ASC Covered Ancillary Services Integral to Covered Surgical
- Procedures for CY 2008 (Including Ancillary Services for Which Payment Is Packaged)
- Addendum D1--OPPS Payment Status Indicators
- Addendum DD1--ASC Payment Indicators
- Addendum D2--OPPS Comment Indicators
- Addendum DD2--ASC Comment Indicators

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Addendum (E – M)

- Addendum E - HCPCS Codes That Would Be Paid Only as Inpatient Procedures for CY 2008
- Addendum L - Out-Migration Adjustment
- Addendum M - HCPCS Codes for Assignment to Composite APCs for CY 2008

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SI - A

Addendum D1.--Payment Status Indicators

Indicator	Item/Code/Service	OPPS Payment Status
A	Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPPS, for example:	Not paid under OPPS. Paid by fiscal intermediaries/MACs under a fee schedule or payment system other than OPPS.
	• Ambulance Services	
	• Clinical Diagnostic Laboratory Services	Not subject to deductible or coinsurance.
	• Non-Implantable Prosthetic and Orthotic Devices	
	• EPO for ESRD Patients	
	• Physical, Occupational, and Speech Therapy	
	• Routine Dialysis Services for ESRD Patients Provided in a Certified Dialysis Unit of a Hospital	
	• Diagnostic Mammography	
• Screening Mammography	Not subject to deductible.	

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Status Indicators – B & C

B	Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x).	Not paid under OPPS. <ul style="list-style-type: none"> • May be paid by fiscal intermediaries/MACs when submitted on a different bill type, for example, 75x (CORF), but not paid under OPPS. • An alternate code that is recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x) may be available.
C	Inpatient Procedures	Not paid under OPPS. Admit patient. Bill as inpatient.

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SI D&E

Indicator	Item/Code/Service	OPPS Payment Status
D	Discontinued Codes	Not paid under OPPS or any other Medicare payment system.
	Items, Codes, and Services:	Not paid under OPPS or any other Medicare payment system.
E	<ul style="list-style-type: none"> • That are not covered by Medicare based on statutory exclusion. 	
	<ul style="list-style-type: none"> • That are not covered by Medicare for reasons other than statutory exclusion. 	
	<ul style="list-style-type: none"> • That are not recognized by Medicare but for which an alternate code for the same item or service may be available. 	
	<ul style="list-style-type: none"> • For which separate payment is not provided by Medicare 	

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SI F - K

F	Corneal Tissue Acquisition; Certain CRNA Services and Hepatitis B Vaccines	Not paid under OPPS. Paid at reasonable cost.
G	Pass-Through Drugs and Biologicals	Paid under OPPS; separate APC payment includes pass-through amount.
H	Pass-Through Device Categories	Separate cost-based pass-through payment; not subject to copayment.
K	(1) Nonpass-Through Drugs and Biologicals	(1) Paid under OPPS; separate APC payment.
	(2) Therapeutic Radiopharmaceuticals	(2) Paid under OPPS; separate APC payment.
	(3) Brachytherapy Sources	(3) Paid under OPPS; separate APC payment.
	(4) Blood and Blood Products	(4) Paid under OPPS; separate APC payment.

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Status Indicators L - N

Indicator	Item/Code/Service	OPPS Payment Status
L	Influenza Vaccine; Pneumococcal Pneumonia Vaccine	Not paid under OPPS. Paid at reasonable cost; not subject to deductible or coinsurance.
M	Items and Services Not Billable to the Fiscal Intermediary/MAC	Not paid under OPPS.
N	Items and Services Packaged into APC Rates	Paid under OPPS; payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment.

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Status Indicators P & Q

P	Partial Hospitalization	Paid under OPPS; per diem APC payment.
Q	Packaged Services Subject to Separate Payment under OPPS Payment Criteria.	Paid under OPPS; Addendum B displays APC assignments when services are separately payable.
		(1) Separate APC payment based on OPPS payment criteria. (2) If criteria are not met, payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment.

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Status Indicators S - Y

S	Significant Procedure, Not Discounted when Multiple	Paid under OPPS; separate APC payment.
T	Significant Procedure, Multiple Reduction Applies	Paid under OPPS; separate APC payment.
V	Clinic or Emergency Department Visit	Paid under OPPS; separate APC payment.
X	Ancillary Services	Paid under OPPS; separate APC payment.
Y	Non-Implantable Durable Medical Equipment	Not paid under OPPS. All institutional providers other than home health agencies bill to DMERC.

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OPPS Comment Indicators

Addendum D2.—Comment Indicators

Comment Indicator	Descriptor
NI	New code, interim APC assignment; comments will be accepted on the interim APC assignment for the new code.
CH	Active HCPCS code in current year and next calendar year, status indicator and/or APC assignment has changed; or active HCPCS code that will be discontinued at the end of the current calendar year.

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Payment Rates

The individual APC's RW (*Relative Weight*)
multiplied by the CF (*Conversion Factor*)
= the payment rate for that APC

*Note: CF is \$63.694 for CY 2008
(up from CY 2007 CF of \$61.468)*

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Financial Updates

- The projected increase in overall payments to hospitals under OPSS for 2008 is \$36 billion (up 10% from \$32.7 billion in 2007).
- CMS estimates that hospitals will receive an overall average increase of 3.8% in Medicare payments for outpatient services in CY 2008.

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Financial Updates

TABLE 4.—PERCENTAGE INCREASE IN VOLUME AND INTENSITY OF HOSPITAL OUTPATIENT SERVICES

	CY 2002	CY 2003	CY 2004	CY 2005	CY 2006 (Est.)	CY 2007 (Est.)	CY 2008 (Est.)
Percent Increase	3.5	2.5	7.6	7.4	10.1	9.4	5.8

Based on the Mission Review of the President's FY 2008 Budget

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Financial Updates (TOPS)

- Transitional outpatient payment (TOPS)
 - Section 5105 of Pub. L. 109-171 reinstated the hold harmless transitional outpatient payments (TOP's) for covered outpatient department services furnished on or after January 1, 2006, and before January 1, 2009. This change involves rural hospitals having 100 or fewer beds that are not SCH's.
 - When the OPSS payment is less than the payment the provider would have received under the previous reasonable cost-based system, the amount of payment is increased by 95 percent of the amount of the difference between the two payment systems for CY 2006, by 90 percent of the amount of that difference for CY 2007, and by 85 percent of the amount of that difference for CY 2008.

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Financial Updates (Hospital types)

- Financial impact in CY 2008 (Table 61)
 - 3.8% increase overall (all hospitals)
 - 3.9% increase large urban hospitals
 - 3.9% increase other urban hospitals
 - 3.1% increase rural hospitals
 - 3.0% increase rural sole community hospitals

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Financial Updates-Outliers

- For CY 2008, Medicare will continue to make an outlier payment that equals 50 percent of the amount by which the cost of furnishing the service exceeds 1.75 times the APC payment amount when both the 1.75 multiple threshold and the fixed-dollar \$1,575 threshold are met.

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Financial Updates-Outliers

- Note that beginning in CY 2008, brachytherapy sources will be eligible for outlier payment.
- In addition, the costs of diagnostic radiopharmaceuticals and contrast media for which CY 2008 payment is packaged into the APC payments for nuclear medicine and other imaging procedures under the final packaging approach will contribute to a claim's eligibility for outlier payment in CY 2008.
- For CMHC's the outlier payment is calculated at 50% of the amount by which the cost exceeds 3.4 times the APC payment rate.

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OPPS 2008 – Packaging Approach

- Packaging of services including:
 - Guidance Services
 - Image processing services
 - Intra-operative services
 - Imaging Supervision and Interpretation Services
 - Diagnostic Radiopharmaceuticals
 - Contrast Media
 - Certain Observation Services

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OPPS 2008 – Packaging Approach

- Each HCPCS code we discuss in this section has a status indicator of either “N” or “Q.”
- The payment for a HCPCS code with a status indicator of “N” is unconditionally packaged so that its payment is always incorporated into the payments for the separately paid services with which it is reported.
- Payment for a HCPCS code with a status indicator of “Q” is either packaged or separately paid, depending on the services with which it is reported.

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OPPS 2008 – Packaging Approach

- Payment for a HCPCS code with a status indicator of “Q” that is “STVX-packaged” is packaged unless the HCPCS code is not reported on the same day with a service that has a status indicator of “S,” “T,” “V,” or “X,” in which case it would be paid separately.
- Payment for a HCPCS code with a status indicator of “Q” that is “Tpackaged” is packaged unless the HCPCS code is not reported on the same day with a service that has a status indicator of “T,” in which case it would be paid separately.

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OPPS 2008 – Packaging Approach

- Payment for a HCPCS code with a status indicator of “Q” that is assigned to a composite APC is packaged into the payment for the composite APC when the criteria for payment of the composite APC are met.

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Packaging Approach – Examples

Example 1: Myelography and Lumbosacral CT with Contrast

HCPCS Code	Descriptor	CY 2007 APC	CY 2007 SI	CY 2007 Payment	CY 2008 Proposed Payment	CY 2008 APC	CY 2008 SI	CY 2008 Final Payment
72265	Contrast X-ray lower spine	0274	S	\$157.01	pkg	0274	Q	\$481.46
72132	CT lumbar spine w/dye	0283	S	\$250.94	\$751.09	0283	S	\$277.48
Sum				\$407.95	\$751.09			\$758.94

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Packaging Approach – Examples

Example 4: Diagnostic Angiography with Balloon Angioplasty of Superficial Femoral Artery

HCPCS Code	Descriptor	CY 2007 APC	CY 2007 SI	CY 2007 Payment	CY 2008 Proposed Payment	CY 2008 APC	CY 2008 SI	CY 2008 Final Payment
75625	Contrast Xray exam of aorta	0280	S	\$1,279.92	pkg	0279	Q	pkg
75716	Artery Xrays, arms/legs	0280	S	\$1,279.92	pkg	0279	Q	pkg
75774	Artery Xray, each vessel	0279	S	\$584.32	pkg	na	N	pkg
75774	Artery Xray, each vessel	0279	S	\$584.32	pkg	na	N	pkg
36247	Place catheter in artery		N	pkg	pkg	na	N	pkg
35474	Repair	0081	T	\$2,639.19	\$2,934.24	0083	T	\$2,890.72

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Packaging Approach – Table 10

TABLE 10.—CY 2008 PACKAGED HCPCS CODES INCLUDED IN SEVEN PACKAGING CATEGORIES

2008 HCPCS Code (1)	Short Descriptor (2)	CY 2007 SI (3)	CY 2007 APC (4)	Final CY 2008 SI (5)	"STVX-Packaged" or "I-Packaged" (6)	Final CY 2008 APC (7)	Category (8)
19295	Place breast clip, percut	S	0657	N	n/a	n/a	Guidance
20975	Electrical bone stimulation	X	0340	N	n/a	n/a	Intraoperative
20985	Cptr-asst dir ms px	n/a	n/a	N	n/a	n/a	Guidance
20986	Cptr-asst dir ms px io img	n/a	n/a	N	n/a	n/a	Guidance
20987	Cptr-asst dir ms px pre img	n/a	n/a	N	n/a	n/a	Guidance
31620	Endobronchial us add-on	S	0670	N	n/a	n/a	Intraoperative

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Packaging Approach – Table 10

TABLE 10.—CY 2008 PACKAGED HCPCS CODES INCLUDED IN SEVEN PACKAGING CATEGORIES

73115	Contrast x-ray of wrist	S	0275	Q	T	0275	Imaging S&I
73525	Contrast x-ray of hip	S	0275	Q	T	0275	Imaging S&I
73530	X-ray exam of hip	X	0261	N	n/a	n/a	Intraoperative
73542	X-ray exam, sacroiliac joint	S	0275	Q	T	0275	Imaging S&I

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Partial Hospitalization

- Partial hospitalization is an intensive outpatient program of psychiatric services provided to patients as an alternative to inpatient psychiatric care for beneficiaries who have an acute mental illness.
- A partial hospitalization program (PHP) may be provided by a hospital to its outpatients or by a Medicare-certified community mental health center (CMHC).

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Partial Hospitalization

- Adopted the proposed rule (72 FR 42692) which developed an alternate way to determine median cost by computing a separate per diem cost for each day rather than for each bill. Under this method, a cost is computed separately for each day of PHP care. When there are multiple days of care entered on a claim, a unique cost is computed for each day of care. All of these costs are then arrayed from lowest to highest and the middle value of the array would be the median per diem cost.

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Adjusted Medicare Payment

- Calculation of an Adjusted Medicare Payment from the National Unadjusted Medicare Payment

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New HCPCS and CPT Codes

- Implantation of Interstitial Devices (APC 0156)
- Other New HCPCS Codes Implemented in April or July 2007

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New non-drug HCPCS codes July 2007

Table 12

HCPCS Code	Long Descriptor	Final CY 2008 Status Indicator	Final CY 2008 APC	Final CY 2008 Median Cost
C2638	Brachytherapy source, stranded, iodine-125, per source	K	2638	\$45
C2639	Brachytherapy source, non-stranded, iodine-125, per source	K	2639	\$32
C2640	Brachytherapy source, stranded, palladium-103, per source	K	2640	\$65

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New non-drug HCPCS codes July 2007

Table 12

C2641	Brachytherapy source, non-stranded, palladium-103, per source	K	2641	\$51
C2642	Brachytherapy source, stranded, cesium-131, per source	K	2642	\$97
C2643	Brachytherapy source, non-stranded, cesium-131, per source	K	2643	\$63
C2698	Brachytherapy source, stranded, not otherwise specified, per source	K	2698	\$45

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New non-drug HCPCS codes July 2007

Table 12

C2699	Brachytherapy source, non-stranded, not otherwise specified, per source	K	2699	\$31
C9728	Placement of interstitial device(s) for radiation therapy/surgery guidance (eg, fiducial markers, dosimeter), other than prostate (any approach) single or multiple	T	0156	\$192

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New Drug HCPCS codes July 2007

Table 13

New HCPCS J-Code Effective January 1, 2008	HCPCS Q-Code	Long Descriptor	Final CY 2008 Status Indicator	Final CY 2008 APC
J1568	Q4087	Injection, immune globulin, (Octagam), intravenous, non-lyophilized, (e.g. liquid), 500 mg	K	0943
J1569	Q4088	Injection, immune globulin, (Gammagard), intravenous, non-lyophilized, (e.g. liquid), 500 mg	K	0944
J2791	Q4089	Injection, rho(d) immune globulin (Inman), (Rhophylac), intravenous, 100 ml	K	0945
J1571	Q4090	Injection, hepatitis b immune globulin (Hepegam B), intramuscular, 0.5 ml	K	0946
J1572	Q4091	Injection, immune globulin, (Flebogamma), intravenous, non-lyophilized, (e.g. liquid), 500 mg	K	0947
J1561	Q4092	Injection, immune globulin, (Gammux), intravenous, non-lyophilized, (e.g. liquid), 500 mg	K	0948
J3488	Q4095	Injection, zoledronic acid (Reclast), 1 mg	K	0951

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Category III CPT Codes

- AMA issues Category III codes in January and July of each year
- July, 2007 codes will become effective 1/1/08

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Category III CPT Codes

TABLE 14.—CATEGORY III CPT CODES IMPLEMENTED IN JULY 2007

CPT Code	Long Descriptor	Final CY 2008 Status Indicator	Final CY 2008 APC
0178T	Electrocardiogram, 64 leads or greater, with graphic presentation and analysis; with interpretation and report	B	Not applicable
0179T	Electrocardiogram, 64 leads or greater, with graphic presentation and analysis; tracing and graphics only, without interpretation and report	X	0100
0180T	Electrocardiogram, 64 leads or greater, with graphic presentation and analysis; interpretation and report only	B	Not applicable
0181T	Corneal hysteresis determination, by air impulse stimulation, bilateral, with interpretation and report	S	0230
0182T	High dose rate electronic brachytherapy, per fraction	S	1519

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New Technology APC's



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New Technology APC's

Positron Emission Tomography (PET) / Computed Tomography (CT) Scans (APC 0308)

- Assign concurrent PET/CT scan procedures described by CPT codes 78814, 78815, and 78816 to clinical APC 0308, with a CY 2008 median cost of approximately \$1,044, which includes packaged costs for diagnostic radiopharmaceuticals used in the scans.

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New Technology APC's

IVIG Preadministration-Related Services (APC 0430)

- Assign HCPCS code G0332 to APC 0430, with a median cost of approximately \$37.

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New Technology APC's

Breast Brachytherapy Catheter Implantation (APC 0648)

- Reassign CPT code 19298 to APC 0648, with a median cost of approximately \$3,560.

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New Technology APC's

Preoperative Services for Lung Volume Reduction Surgery (LVRS) (APCs 0209 and 0213)

- HCPCS codes G0302 and G0303 are assigned to APC 0209, with a CY 2008 median cost of approximately \$710.
- HCPCS codes G0304 and G0305 are assigned to APC 0213, with a CY 2008 median cost of approximately \$145.

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New Technology APC's (Table 16)

TABLE 16.—FINAL CY 2008 APC REASSIGNMENTS OF OTHER
NEW TECHNOLOGY PROCEDURES TO CLINICAL APCs

HCPCS Code	Short Descriptor	CY 2007 SI	CY 2007 APC	CY 2007 APC Payment Rate	Final CY 2008 SI	Final CY 2008 APC	Final CY 2008 APC Median Cost
19298	Place breast rad tube/cath	S	1524	\$3,250	T	0648	\$3,560
G0302	Pre-op service LVRS complete	S	1509	\$750	S	0209	\$710
G0303	Pre-op service LVRS 10-15dn	S	1507	\$550	S	0209	\$710
G0304	Pre-op service LVRS 1-9 dn	S	1504	\$250	S	0213	\$145
G0305	Post op service LVRS min 6	S	1504	\$250	S	0213	\$145

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APC Specific Policies



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Cardiac Procedures

- Cardiac Computed Tomography and Computed Tomographic Angiography (APCs 0282 and 0383)

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Cardiac Procedures (CCT & CTA)

HCPCS Code	Short Descriptor	CY 2007 \$1	CY 2007 APC	CY 2007 APC Median Cost	Final CY 2008 \$1	Final CY 2008 APC	Final CY 2008 APC Median Cost
0144T	CT heart w/o dye; qual calc	0	0398	\$252	0	0282	\$100
0145T	CT heart w/w/o dye funct	0	0376	\$306	0	0383	\$296
0146T	CCTA w/w/o dye	0	0376	\$306	0	0383	\$296
0147T	CCTA w/w/o, quan calcium	0	0376	\$306	0	0383	\$296
0148T	CCTA w/w/o, strax	0	0377	\$397	0	0383	\$296
0149T	CCTA w/w/o, strax quan calc	0	0377	\$397	0	0383	\$296
0150T	CCTA w/w/o, disease strax	0	0398	\$252	0	0383	\$296
0151T	CT heart funct add-on	0	0282	\$94	0	0282	\$100

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Cardiac Procedures

Coronary and Non-Coronary Angioplasty (PTCA/PTA) (APCs 0082, 0083, and 0103)

- Reassign angioplasty procedures assigned to APC 0081 in CY 2007 to APC 0083 in CY 2008. The median cost of APC 0083 is approximately \$2,855.

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Cardiac Procedures

Implantation of Cardioverter-Defibrillators (APCs 0107 and 0108)

- CMS did NOT finalize the CY 2008 proposal to assign CPT code 33284 to APC 0109.
- Instead, they are reassigning CPT code 33284 to APC 0020 for CY 2008, with a median cost of approximately \$546.

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Cardiac Procedures

Stress Echocardiography (APC 0697)

- CMS did NOT finalize the proposal to assign noncontrast studies reported with CPT code 93350 to APC 0697, which has the new APC title of “Level I Echocardiogram Without Contrast Except Esophageal”.
- Instead, they retained the assignment of CPT code 93350 for noncontrast studies to APC 0269, which has the new APC title of “Level II Echocardiogram Without Contrast Except Transesophageal”

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Cardiac Procedures

- Contrast studies reported with the corresponding C-code to CPT code 93350, specifically C8928, are assigned to APC 0128, with a CY 2008 median cost of approximately \$534.

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Cardiac Procedures

Coronary or Non-Coronary Atherectomy (APC 0082)

- Reconfigured APC 0082 for the CY 2008 OPPS by adding 11 CPT codes, most of which were for percutaneous atherectomy procedures, and changed its title to “Coronary or Non-Coronary Atherectomy”
- Median cost of approximately \$5,506.

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Gastrointestinal Procedures

Computed Tomographic Colonography (APC 0332)

- Reassign diagnostic computed tomographic colonography, specifically described by CPT code 0067T (Computed tomographic (CT) colonography (i.e., virtual colonoscopy); diagnostic), from APC 0333 (Computed Tomography without Contrast followed by Contrast) to APC 0332 (Computed Tomography without Contrast), with a median cost of about \$189 for CY 2008.

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Gastrointestinal Procedures

Laparoscopic Neurostimulator Electrode Implantation (APC 0130)

- NOT finalizing the CY 2008 proposal to assign CPT code 43647 to APC 0130.
- Instead, CMS will reassign CPT code 43647 to APC 0061, with a median cost of approximately \$5,213.
- In addition, they are changing the title of APC 0061 to “Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve” to better reflect all of the procedures assigned to the APC for CY 2008.

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Gastrointestinal Procedures

Screening Colonoscopies and Screening Flexible Sigmoidoscopies (APCs 0158 and 0159)

- Since the implementation of the OPSS in August 2000, screening colonoscopies and screening flexible sigmoidoscopies have been paid separately.
- For CY 2008, CMS will pay for screening colonoscopies and screening flexible sigmoidoscopies under the OPSS at payment rates developed according to the standard OPSS ratesetting methodology.

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Genitourinary Procedures

Cystoscopy with Stent (APC 0163)

- Assignment of CPT code 52282 (Cystourethroscopy, with insertion of urethral stent) to APC 0163 (Level IV Cystourethroscopy and other Genitourinary Procedures), with a CY 2008 median cost of approximately \$2,270.

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Genitourinary Procedures

Percutaneous Renal Cryoablation (APC 0423)

- For CY 2008, the CPT Editorial Panel decided to delete CPT code 0135T on December 31, 2007, and replace it with CPT code 50593 (Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy).
- The replacement CPT code 50593 will be assigned to APC 0423 effective January 1, 2008.
- Similar to its predecessor code, we expect hospitals to report both the device HCPCS code C2618 and CPT code 50593 to appropriately report the renal cryoablation procedure.

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Genitourinary Procedures

Prostatic Thermotherapy (APC 0163)

- CY 2008 assignments of CPT codes 53850 and 53852 to APC 0429, with a median cost of approximately \$2,844.

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Genitourinary Procedures

Radiofrequency Ablation of Prostate (APC 0163)

- Reassign CPT code 53852 to APC 0429, with a median cost of approximately \$2,844.

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Genitourinary Procedures

Ultrasound Ablation of Uterine Fibroids with Magnetic Resonance Guidance (MRgFUS) (APC 0067)

- Assignment of CPT codes 0071T and 0072T to APC 0067, with a CY 2008 median cost of approximately \$3,882.

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Genitourinary Procedures

TABLE 18.—FINAL CY 2008 APC ASSIGNMENTS OF MRgFUS PROCEDURES

HCPCS Code	Short Descriptor	CY 2007 SI	CY 2007 APC	CY 2007 APC Median Cost	Final CY 2008 SI	Final CY 2008 APC	Final CY 2008 APC Median Cost
0071T	U/s leiomyomata ablate <200	T	0195	\$ 1,742	S	0067	\$3,882
0072T	U/s leiomyomata ablate >200	T	0202	\$ 2,534	S	0067	\$3,882

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Genitourinary Procedures

Uterine Fibroid Embolization (APC 0202)

- Reassign CPT code 37210 for uterine fibroid embolization to APC 0229, with a median cost of approximately \$5,570.

63

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Nervous System Procedures

Chemodenervation (APC 0206)

- Modified the CY 2008 proposed assignments of CPT codes 64650 and 64653 and retaining these two CPT codes in APC 0204, with a median cost of approximately \$146, rather than reassigning them to APC 0206 as proposed.

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Nervous System Procedures

Implantation of Intrathecal or Epidural Catheter (APC 0224)

- Deleted APC 0223 and reassign CPT code 62350 to APC 0224, with a median cost of approximately \$2,282.

65

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Nervous System Procedures

Implantation of Spinal Neurostimulators (APC 0222)

- Implemented a revised APC configuration for neurostimulator implantation procedures that packages payment for procedures involving mainly nonrechargeable neurostimulator technology (i.e., cranial, sacral, gastric, or other peripheral neurostimulators) into two APCs (APCs 0039 and 0315)
- Established a single APC for spinal neurostimulator implantation, which commonly utilizes either rechargeable or nonrechargeable technologies (APC 0222).

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Neurostimulator

TABLE 19—CY 2008 APC CONFIGURATION FOR PAYMENT OF RECHARGEABLE AND NONRECHARGEABLE NEUROSTIMULATOR IMPLANTATION PROCEDURES

APC	Revised Title for CY 2008	Previous Title	HCPCS Codes Included in CY 2008 Median Cost	HCPCS Descriptor	CY 2008 CPT Code Median Cost	CY 2008 APC Median Cost
0319	Level I Implantation of Neurostimulator	Level I Implantation of Neurostimulator	6145	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling, with connections to a single electrode array	\$12,769	\$11,702
			6150	Insertion or replacement of peripheral neurostimulator pulse generator or receiver, direct or inductive coupling	\$10,854	\$11,702
0322	Level II Implantation of Neurostimulator	Implantation of Neurological Device	6155	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling	\$15,150	\$15,150
0315	Level III Implantation of Neurostimulator	Level II Implantation of Neurostimulator	6140	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling, with connections to two or more electrode arrays	\$16,000	\$16,000

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Nuclear Medicine and Radiation Oncology Procedures

Adrenal Imaging (APC 0391)

- Reassigned CPT code 78075 to APC 0408, with a CY 2008 median cost of approximately \$969, rather than to APC 0391 as proposed.

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Nuclear Medicine and Radiation Oncology Procedures

Injection for Sentinel Node Identification (APC 0389)

- Reassigned CPT code 38792 to APC 0392, with a CY 2008 median cost of approximately \$183, rather than to APC 0389 as proposed.

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Nuclear Medicine and Radiation Oncology Procedures

Myocardial Positron Emission Tomography (PET) Scans (APC 0307)

- Payment for all myocardial PET scans through APC 0307, with a CY 2008 median cost of approximately \$1,384

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Nuclear Medicine and Radiation Oncology Procedures

TABLE 20.—FINAL CY 2008 APC ASSIGNMENTS FOR MYOCARDIAL PET SCANS

HCPCS Code	Short Descriptor	CY 2007 SI	CY 2007 APC	CY 2007 APC Median Cost	Final CY 2008 SI	Final CY 2008 APC	Final CY 2008 APC Median Cost
78459	Heart muscle imaging (PET)	S	0307	\$727	S	0307	\$ 1,384
78491	Heart image (pet), single	S	0307	\$727	S	0307	\$ 1,384
78492	Heart image (pet), multiple	S	0307	\$727	S	0307	\$ 1,384

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Nuclear Medicine and Radiation Oncology Procedures

Nonmyocardial Positron Emission Tomography (PET) Scans (APC 0308)

- Assignment of CPT code 78608 to APC 0308, with a CY 2008 median cost of approximately \$1,044.

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Nuclear Medicine and Radiation Oncology Procedures

Proton Beam Therapy (APCs 0664 and 0667)

- Assign CPT codes 77520 and 77522 to APC 0664, with a median cost of approximately \$807
- Assign CPT codes 77523 and 77525 to APC 0667, with a median cost of approximately \$965.

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Ocular and Ear, Nose, and Throat Procedures

Amniotic Membrane for Ocular Surface Reconstruction (APC 0244)

- Assign HCPCS code V2790 (Amniotic membrane for surgical reconstruction, per procedure) status indicator "N" (packaged) for CY 2008 and to assign its related CPT procedure codes to APC 0244 (Corneal Transplant).
- Changed the APC title for APC 0244 from "Corneal Transplant" to "Corneal and Amniotic Membrane Transplant," effective January 1, 2008, to ensure that the title better describes all procedures assigned to that APC.

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Ocular and Ear, Nose, and Throat Procedures

Keratoprosthesis (APC 0293)

- Assign CPT code 65570 to APC 0293 as proposed.
- Designated APC 0293 as a device-dependent APC, with a median cost of approximately \$5,335.

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Ocular and Ear, Nose, and Throat Procedures

Palatal Implant (APC 1510)

- Pay \$850 for HCPCS code C9727 (Insertion of implants into the soft palate; minimum of three implants) through its assignment to New Technology APC 1510 (New Technology—Level X (\$800 - \$900)). This is the same APC assignment for the service as its CY 2007 placement.

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Orthopedic Procedures

Arthroscopic Procedures (APCs 0041 and 0042)

- Reassigned several arthroscopic procedures to APCs 0041 and 0042, as displayed in Table 21 below.

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Arthroscopic Procedures

TABLE 21—CY 1998 APC REASSIGNMENT OF ARTHROSCOPIC PROCEDURES

HCPCS Code	Short Description	CY 1997 APC Assignment	CY 1997 APC Median Cost	CY 1998 APC Assignment	CY 1998 APC Median Cost
29113	Shoulder arthroscopy, arthroscopy	0041	11,740	0042	11,876
29123	Shoulder arthroscopy, arthroscopy	0041	11,740	0042	11,876
29121	Shoulder arthroscopy, arthroscopy	0041	11,740	0042	11,876
29122	Shoulder arthroscopy, arthroscopy	0041	11,740	0042	11,876
29125	Shoulder arthroscopy, arthroscopy	0041	11,740	0042	11,876
29147	Wrist arthroscopy, arthroscopy	0041	11,740	0042	11,876
29159	Wrist arthroscopy, arthroscopy	0041	11,740	0042	11,876
29128	Hip arthroscopy, arthroscopy	0041	11,740	0042	11,876
29145	Hip arthroscopy, arthroscopy	0041	11,740	0042	11,876
29191	Ankle arthroscopy, arthroscopy	0041	11,740	0042	11,876
29192	Ankle arthroscopy, arthroscopy	0041	11,740	0042	11,876
29028	Knee joint arthroscopy, arthroscopy	0013	10,077	0041	11,811
29091	Knee joint arthroscopy, arthroscopy	0013	10,077	0041	11,811
29092	Knee joint arthroscopy, arthroscopy	0013	10,077	0041	11,811

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Orthopedic Procedures

Closed Fracture Treatment (APC 0043)

- Continue the assignment of various CPT codes that describe closed treatment of fractures of the fingers, toes, and trunk to APC 0043 (Closed Treatment Fracture Finger/Toe/Trunk).
- Median cost of about \$111 for CY 2008.

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Orthopedic Procedures

Insertion of Posterior Spinous Process Distraction Device (APC 0050)

- Assign CPT codes 0171T and 0172T to APC 0050, with a median cost of approximately \$1,836.

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Orthopedic Procedures

Intradiscal Annuloplasty (APC 0050)

- Assign CPT codes 22526 and 22527 to APC 0050, with a median cost of approximately \$1,836.

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Orthopedic Procedures

Kyphoplasty Procedures (APC 0052)

- Assign CPT codes 22523, 22524, and 22525 to APC 0052, with a median cost of approximately \$4,997.

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Vascular Procedures

Blood Transfusion (APC 0110)

- Longstanding policy under the OPPS that blood transfusion services are billed and paid on a per encounter basis and not by the number of units of blood products transfused.
- Under this policy, a transfusion APC payment is made to the OPPS provider for transfusing blood products once per day, regardless of the number of units or different types of blood products transfused.

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Vascular Procedures

Blood Transfusion (APC 0110)

- Continue to pay hospitals for only one unit of CPT code 36430 on a single date of service.
- Did NOT adopt the APC Panel's March 2007 recommendation to provide a separate payment for each unit of blood or blood product transfused.
- Because the payment for one unit of APC 0110, with a final CY 2008 median cost of approximately \$214, is based on the costs of all transfusion services provided in a hospital outpatient encounter, CMS reminds hospitals that a claim for a single unit of CPT code 36430 should include charges for all of the hospital resource costs associated with the totality of transfusion services furnished on the date of service.

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Vascular Procedures

Endovenous Ablation (APC 0092)

- Assign CPT code 36478 to APC 0092, with a median cost of about \$1,626.

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Vascular Procedures

Insertion of Central Venous Access Device (APC 0625)

- Pay for CPT code 36566 through device dependent APC 0625, with a median cost of approximately \$5,143.
- No change in the short descriptor for pass-through device category C1881.

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Vascular Procedures

Noninvasive Vascular Studies (APC 0267)

- Payment for APCs 0267 and 0269 based on costs from claims, according to the standard OPPS methodology, with median costs of approximately \$150 and \$404, respectively.
- For CY 2008, APC 0269 will be paid specifically for noncontrast echocardiography studies.

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Other Procedures

Hyperbaric Oxygen Therapy (APC 0659)

- Estimated a “per unit” median cost for HCPCS code C1300, assigned to APC 0659, with a median cost of approximately \$98 based on 67,435 claims with multiple units or multiple occurrences.

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Other Procedures

Skin Repair Procedures (APCs 0133, 0134, 0135, 0136, and 0137)

- Finalized the CY 2008 proposed reconfiguration of the skin substitute and skin replacement APCs, without modification, as shown in Table 22 below

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Skin Repair

HCPCS Code	Short Descriptor	CY 2008 APC	CY 2008 APC Median Cost
11950	Therapy for contour defects	0133	\$80
11951	Therapy for contour defects		
11952	Therapy for contour defects		
11954	Therapy for contour defects		
12001	Repair superficial wound(s)		
12002	Repair superficial wound(s)		
12004	Repair superficial wound(s)		
12005	Repair superficial wound(s)		
12006	Repair superficial wound(s)		
12007	Repair superficial wound(s)		
12011	Repair superficial wound(s)		
12013	Repair superficial wound(s)		
12014	Repair superficial wound(s)		
12015	Repair superficial wound(s)		
12016	Repair superficial wound(s)		
12017	Repair superficial wound(s)		
12018	Repair superficial wound(s)		
12031	Layer closure of wound(s)		
12041	Layer closure of wound(s)		
12051	Layer closure of wound(s)		
12052	Layer closure of wound(s)		
12053	Layer closure of wound(s)		
15775	Hair transplant punch grafts		
15776	Hair transplant punch grafts		

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Skin Repair
 APC 0135
 Median Cost \$285

15300	Apply skinlogrft, tiarm/lig		
15301	Apply skinlogrft tiail addl		
15320	Apply skin allogrft fin/hf/ig		
15321	Apply skinlogrft fin/hf/ig add		
15330	Apply acell allogrft tiarm/leg		
15331	Apply acell grft tiail add-on		
15335	Apply acell graft, fin/hf/ig		
15336	Apply acell grft fin/hf/ig add		
15350	Skin homograft		
15351	Skin homograft add-on		
15400	Apply skin xenograft, tiail		
15401	Apply skin xenograft tiail add		
15420	Apply skin xgrft, fin/hf/ig		
15421	Apply skin xgrft fin/hf/ig add		
15430	Apply acellular xenograft		
15431	Apply acellular xgrft add		
20926	Removal of tissue for graft		
43687	Remove gastric port, open		

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Skin Repair

11762	Reconstruction of nail bed	0136	9947
14000	Skin tissue rearrangement		
14001	Skin tissue rearrangement		
14020	Skin tissue rearrangement		
14021	Skin tissue rearrangement		
14040	Skin tissue rearrangement		
14041	Skin tissue rearrangement		
14060	Skin tissue rearrangement		
14061	Skin tissue rearrangement		
15130	Derm autograft, tmk/arm/leg		
15131	Derm autograft tiail add-on		
15136	Derm autograft face/neck/hf/ig		
15136	Derm autograft, fin/hf/ig add		
15200	Skin full graft, trunk		
15201	Skin full graft trunk add-on		
15220	Skin full graft scpl/arm/leg		
15240	Skin full grft face/genit/hf		
15260	Skin full graft een & lips		
15281	Skin full graft add-on		
15740	Island pedicle flap graft		
15936	Remove sacrum pressure sore		
15952	Remove thigh pressure sore		
15953	Remove thigh pressure sore		
15956	Remove thigh pressure sore		
15958	Remove thigh pressure sore		
20920	Removal of fascia for graft		
20922	Removal of fascia for graft		
23921	Amputation follow-up surgery		
25929	Amputation follow-up surgery		
33222	Revise pocket, pacemaker		
33223	Revise pocket, pacino-defib		

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Skin Repair

11960	Insert tissue expander(s)	0137	\$1,271
13160	Late closure of wound		
14300	Skin tissue rearrangement		
14350	Skin tissue rearrangement		
15100	Skin split grft, trunk/arm/leg		
15101	Skin split grft trial, add-on		
15120	Skin split a-grft fac/ck/h/fig		
15121	Skin split a-grft fin/hfig add		
15570	Form skin pedicle flap		
15572	Form skin pedicle flap		
15574	Form skin pedicle flap		
15576	Form skin pedicle flap		
15600	Skin graft		
15610	Skin graft		
15620	Skin graft		
15630	Skin graft		
15650	Transfer skin pedicle flap		
15731	Forehead flap w/vasc pedicle		
15732	Muscle-skin graft, head/neck		
15734	Muscle-skin graft, trunk		
15736	Muscle-skin graft, arm		
15738	Muscle-skin graft, leg		
15760	Neurovascular pedicle graft		
15760	Composite skin graft		
15770	Derma-fat-fascia graft		
15820	Revision of lower eyelid		
15821	Revision of lower eyelid		
15822	Revision of upper eyelid		
15823	Revision of upper eyelid		
15824	Removal of forehead wrinkles		
15825	Removal of neck wrinkles		
15826	Removal of brow wrinkles		
15828	Removal of face wrinkles		
15829	Removal of skin wrinkles		
15840	Graft for face nerve palsy		
15841	Graft for face nerve palsy		
15842	Flap for face nerve palsy		
15845	Skin and muscle repair, face		
15876	Suction assisted lipectomy		

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Skin Repair APC 0137 Median cost \$1,271

15877	Suction assisted lipectomy		
15878	Suction assisted lipectomy		
15879	Suction assisted lipectomy		
15922	Removal of tail bone ulcer		
15934	Remove sacrum pressure sore		
15935	Remove sacrum pressure sore		
15937	Remove sacrum pressure sore		
15944	Remove hip pressure sore		
15945	Remove hip pressure sore		
15946	Remove hip pressure sore		
20101	Explore wound, chest		
20102	Explore wound, abdomen		
20910	Remove cartilage for graft		
20912	Remove cartilage for graft		
43886	Revise gastric port, open		
43888	Change gastric port, open		
44312	Revision of ileostomy		
44340	Revision of colostomy		

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Skin Repair
 APC 0137
 Median cost \$1,271

15877	Suction assisted lipectomy		
15878	Suction assisted lipectomy		
15879	Suction assisted lipectomy		
15922	Removal of tail bone ulcer		
15934	Remove sacrum pressure sore		
15935	Remove sacrum pressure sore		
15937	Remove sacrum pressure sore		
15944	Remove hip pressure sore		
15945	Remove hip pressure sore		
15946	Remove hip pressure sore		
20101	Explore wound, chest		
20102	Explore wound, abdomen		
20910	Remove cartilage for graft		
20912	Remove cartilage for graft		
43886	Revise gastric port, open		
43888	Change gastric port, open		
44312	Revision of ileostomy		
44340	Revision of colostomy		

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Other Procedures

Stereotactic Radiosurgery (SRS) Treatment Delivery Services (APCs 0065, 0066, and 0067)

- For CY 2007, the CPT Editorial Panel created four new SRS Category I CPT codes in the Radiation Oncology section of the 2007 CPT manual (77371, 77372, 77373, and 77435).
- CPT codes 77371 and 77435 were recognized under the OPPS effective January 1, 2007, while CPT codes 77372 and 77373 were not.

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Other Procedures

Stereotactic Radiosurgery (SRS) Treatment Delivery Services (APCs 0065, 0066, and 0067)

- For CY 2008, to continue the use of the current HCPCS G-codes for LINAC-based SRS treatment delivery services, specifically, HCPCS Gcodes G0173, G0251, G0339, and G0340, under the OPPS.
- CMS will not recognize CPT codes 77372 and 77373 under the CY 2008 OPPS.
- The HCPCS G-codes will continue to be assigned to the same CY 2007 APCs for CY 2008, specifically, APCs 0065, 0066, and 0067, with final APC median costs of approximately \$1,044, \$2,835, and \$3,882, respectively.

Other Procedures

TABLE 23.—FINAL CY 2008 APC ASSIGNMENTS FOR LINAC-BASED SRS TREATMENT DELIVERY SERVICES

HCPCS Code	Short Descriptor	CY 2007 SI	CY 2007 APC	CY 2007 APC Median Cost	Final CY 2008 SI	Final CY 2008 APC	Final CY 2008 APC Median Cost
G0173	Linear acc stereo radour com	S	0067	\$3,873	S	0067	\$ 3,882
G0251	Linear acc based stero radio	S	0065	\$1,242	S	0065	\$ 1,044
G0339	Robot lin-radour com, first	S	0067	\$3,873	S	0067	\$ 3,882
G0340	Robot lin-radour fractx 2-5	S	0066	\$2,630	S	0066	\$ 2,835

Medical Services

Single Allergy Tests (APC 0381)

- Calculate a “per unit” median cost for APC 0381 as described above.
- The CY 2008 median cost of APC 0381 is approximately \$17.

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Medical Services

Continuous Glucose Monitoring (APC 0097)

- Discontinuing APC 0421 and reassigning CPT code 95250 to APC 0607, with a CY 2008 median cost of approximately \$104, rather than to APC 0097 as proposed.

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Medical Services

Home International Normalized Ratio (INR) Monitoring (APC 0097)

- Discontinuing APC 0421 and reassigning HCPCS codes G0248 and G0249 to APC 0607, with a CY 2008 median cost of approximately \$104, rather than to APC 0097 as proposed.

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Medical Services

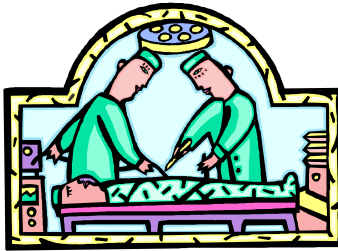
Mental Health Services (APCs 0322, 0323, 0324, and 0325)

- Reassign CPT code 90862 and HCPCS code M0064 from APC 0605 to APC 0606, with a median cost of approximately \$83.

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OPPS Payment Changes For Devices



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Treatment of Device-Dependent APC's

- **CY 2008 Payment Policy**

- Device-dependent APCs are populated by HCPCS codes that usually, but not always, require that a device be implanted or used to perform the procedure.
- The CY 2008 payment rates for device-dependent APCs are based on their median costs calculated from CY 2006 claims and the most recent cost report data, using only claims that pass the device edits, do not contain token charges for devices, and do not have a modifier signifying that the device was furnished without cost or with full credit.

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Treatment of Device-Dependent APC's

- **CY 2008 Payment Policy**

- Differences in payment rates from CY 2007 to CY 2008 to be attributable to a variety of factors, including the availability of more complete claims data for CY 2008 and the packaging approach that is new for CY 2008.
- Added APC 0293 (Level V Anterior Segment Eye Procedures) to the list of device-dependent APCs for CY

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Treatment of Device-Dependent APC's

- **CY 2008 Payment Policy**

- TABLE 24-CY 2008 MEDIAN COSTS FOR DEVICE-DEPENDENT APCs
- TABLE 25-ADJUSTMENTS TO APCs IN CASES OF NO COST OR FULL OR PARTIAL CREDIT FOR REPLACED DEVICES
- TABLE 26-DEVICES FOR WHICH THE "FB" or "FC" MODIFIER MUST BE REPORTED WITH THE PROCEDURE CODE WHEN FURNISHED WITHOUT COST/FULL CREDIT OR PARTIAL CREDIT FOR A REPLACED DEVICE

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FB or FC modifier

Device HCPCS Code	Short Descriptor
C1721	AICD, dual chamber
C1723	AICD, single chamber
C1764	Event recorder, cardiac
C1767	Generator, neurostim, imp
C1771	Rep dev, urinary, w/sling
C1772	Infusion pump, programmable
C1776	Joint device (implantable)
C1777	Lead, AICD, endo single coil
C1778	Lead, neurostimulator
C1779	Lead, pmkr, transvenous VDD
C1785	Pmkr, dual, rate-resp
C1786	Pmkr, single, rate-resp
C1813	Prosthesis, penile, inflatable
C1815	Prost, urinary sph, imp
C1820	Generator, neuro rechg bat sys
C1881	Dialysis access system
C1882	AICD, other than sing/dual
C1891	Infusion pump, non-prog, perm
C1895	Lead, AICD, endo dual coil
C1896	Lead, AICD, non sing/dual
C1897	Lead, neurostim, test kit
C1898	Lead, pmkr, other than trans
C1899	Lead, pmkr/AICD combination
C1900	Lead coronary venous
C2619	Pmkr, dual, non rate-resp
C2620	Pmkr, single, non rate-resp
C2621	Pmkr, other than sing/dual
C2622	Prosthesis, penile, non-inf
C2626	Infusion pump, non-prog, tempo
C2631	Rep dev, urinary, w/o sling
L8614	Cochlear device/system

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Pass-Through Payments for Devices

Expiration of Transitional Pass-Through Payments for Certain Devices

- Under the OPPS, a category of devices be eligible for transitional pass-through payments for at least 2, but not more than 3, years.
- The device category codes became effective April 1, 2001, under the provisions of the BIPA. Prior to pass-through device categories, Medicare payments for pass-through devices under the OPPS were made on a brand-specific basis.

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Pass-Through Payments for Devices

Expiration of Transitional Pass-Through Payments for Certain Devices

- Expire device categories L8690 and C1821 from transitional pass-through payment after December 31, 2008.

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Pass-Through Payments for Devices

Provisions for Reducing Transitional Pass-Through Payments to Offset Costs Packaged into APC Groups

- For CY 2008, CMS will use CY 2006 hospital claims data to calculate device percentages and potential offsets for new device categories established in CY 2008.
- Publish through program transmittals any new or updated offsets that we calculated for CY 2008, corresponding to newly created categories or existing categories eligible for pass-through payment, respectively.

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OPPS Drug Payment Changes



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OPPS Changes-Drugs, Pharmaceuticals & Biologicals

- ***Transitional Pass-Through Payment for Additional Costs of Drugs and Biologicals***
 - Section 1833(t)(6)(C)(i) of the Social Security Act specifies that the duration of transitional pass-through payments for drugs and biologicals must be no less than 2 years and no longer than 3 years.
- CY 2008 pass-through drugs and biologicals are assigned status indicator "G" as indicated in Addenda A and B to the CY 2008 OPPS/ASC proposed rule and this final rule with comment period.

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OPPS Changes-Drugs, Pharmaceuticals & Biologicals

Drugs and Biologicals with Expiring Pass-Through Status in CY 2007

TABLE 27.—DRUGS AND BIOLOGICALS FOR WHICH PASS-THROUGH STATUS EXPIRES DECEMBER 31, 2007

CY 2008 HCPCS	CY 2007 HCPCS	CY 2008 Descriptor	CY 2008 SI	CY 2008 APC
J2278	J2278	Ziconotide injection	K	1694
J2503	J2503*	Pegaptanib sodium injection	K	1697
J7311	J7311	Fluocinolone acetonide implt	K	9225
J8501	J8501	Oral aprepitant	K	0868
J9027	J9027	Clofarabine injection	K	1710
J9264	J9264*	Paclitaxel protein bound	K	1712

* Indicates that the drug was paid at a rate determined by the Part B drug CAP methodology while identified as pass-through under the OPPS.

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OPPS Changes- Drugs&Biologicals

Drugs and Biologicals with Pass-Through Status in CY 2008

TABLE 28.—DRUGS AND BIOLOGICALS WITH PASS-THROUGH STATUS IN CY 2008

CY 2007 HCPCS	CY 2008 HCPCS	CY 2008 Descriptor	CY 2008 SI	CY 2008 APC
	C9239	Imi. temsirolimus	G	1168
C9350	C9352	Neuraxone nerve guide, per cm	G	9350
C9350	C9353	Neuraxone nerve protector, cm	G	1169
J0129	J0129	Abatacept injection	G	9230
CY 2007 HCPCS	CY 2008 HCPCS	CY 2008 Descriptor	CY 2008 SI	CY 2008 APC
J0348	J0348	Anadulofungin injection	G	0760
J0894*	J0894*	Dacitaxine injection	G	9231
C9236	J1300	Eculizumab injection	G	9236
J1740	J1740	Ibandronate sodium injection	G	9229
C9232	J1743	Idosulfase injection	G	9232
J2248	J2248	Micafungin sodium injection	G	9227
Q4079	J2323	Natalizumab injection	G	9126
C9233	J2778	Ramabizumab injection	G	9233
J3243	J3243	Tigecycline injection	G	9228
J3473	J3473	Hyaluronidase recombinant	G	0806
Q4095	J3488	Reclint injection	G	0951
C9351	J7348	Tisotumend tissue	G	9351
C9351	J7349	Primatix tissue	G	1141
J9261	J9261	Nelarabine injection	G	0825
C9235	J9303	Panitumumab injection	G	9235

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OPPS Changes-Drugs, Pharmaceuticals & Biologicals

Payment for Drugs, Biologicals, and Radiopharmaceuticals without Pass- Through Status

- Exempt the oral and injectable forms of 5HT3 anti-emetic products listed in Table 29 below from the packaging methodology for CY 2008.

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OPPS Changes-Drugs, Pharmaceuticals & Biologicals

TABLE 29.—ANTI-EMETICS EXEMPTED FROM CY 2008
\$60 PACKAGING THRESHOLD

HCPCS Code	Short Descriptor
J1260	Dolasetron mesylate
J1626	Granisetron HCl injection
J2405	Ondansetron hcl injection
J2469	Palonosetron HCl
Q0166	Granisetron HCl 1 mg oral
Q0179	Ondansetron HCl 8 mg oral
Q0180	Dolasetron mesylate oral

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OPPS Changes-Drugs, Pharmaceuticals & Biologicals

TABLE 30.—DRUGS AND BIOLOGICALS PROPOSED AS PACKAGED BUT
WITH FINAL PER DAY COSTS ABOVE \$60, FOR WHICH SEPARATE
PAYMENT WILL BE MADE IN CY 2008

HCPSC	Description
J0190	inj biperiden lactate/5 mg
J0600	Edetate calcium disodium inj
J1595	Injection glatiramer acetate
J2730	Pralidoxime chloride inj
J9270	Plicamycin (mithramycin) inj

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OPPS Changes-Drugs, Pharmaceuticals & Biologicals

- Two drugs, specifically HCPSC codes J0520 (injection, bethanechol chloride, myotonachol or urecholine, up to 5 mg) and J3364 (injection, urokinase, 5000 iu vial), will continue to be packaged in CY 2008.

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OPPS Changes-Drugs, Pharmaceuticals & Biologicals

Payment for Drugs and Biologicals without Pass-Through Status That Are Not Packaged

- In CYs 2006 and 2007, CMS finalized a policy of providing payment to HOPDs for drugs, biologicals, and associated pharmacy handling costs at a rate of ASP+6 percent.
- In addition, in CY 2006 they proposed to collect pharmacy overhead charge data via special pharmacy overhead HCPCS codes that hospitals would report.

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OPPS Changes-Drugs, Pharmaceuticals & Biologicals

Payment for Drugs and Biologicals without Pass-Through Status That Are Not Packaged

- For CY 2008, CMS proposed to continue our methodology of providing a combined payment rate for drug and biological acquisition costs and pharmacy overhead.
- In addition, CMS proposed to instruct hospitals to remove the pharmacy overhead charge from the charge for the drug or biological and instead report the pharmacy overhead charge on an uncoded revenue code line on the claim beginning in CY 2008.

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OPPS Changes-Drugs, Pharmaceuticals & Biologicals

Payment for Drugs and Biologicals without Pass-Through Status That Are Not Packaged

- Did NOT finalize the proposal to require hospitals to remove pharmacy overhead costs from drug acquisition costs and to report pharmacy overhead costs in an uncoded revenue code line.
- Adopted the September 2007 recommendation of the APC Panel that pharmacy overhead and handling costs be recognized within drug charges and be paid through the packaged or separate drug payment (as appropriate based on the drug packaging threshold).

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OPPS Changes-Drugs, Pharmaceuticals & Biologicals

Payment for Drugs and Biologicals without Pass-Through Status That Are Not Packaged

- Provide a single bundled payment for separately payable drugs and biologicals, inclusive of both drug acquisition and pharmacy overhead costs.
- Hospitals should continue to consider the costs of pharmacy overhead in developing and reporting their charges for drugs and biologicals, maintaining their current practice.

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OPPS Changes-Drugs, Pharmaceuticals & Biologicals

Payment for Drugs and Biologicals without Pass-Through Status That Are Not Packaged

- Provide a transitional payment of ASP+5 percent for separately payable drugs and biologicals and associated pharmacy overhead in CY 2008 as CMS moves toward a relative ASP percent based on mean costs from claims for CY 2009.

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OPPS Changes-Drugs, Pharmaceuticals & Biologicals

Payment for Drugs and Biologicals without Pass-Through Status That Are Not Packaged

- Provide a 2-year transition for payment for separately payable drugs and biologicals under the OPPS based on the equivalent average ASP-based payment amount calculated from aggregate costs from hospitals claims.

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OPPS Changes-Drugs, Pharmaceuticals & Biologicals

Payment for Blood Clotting Factors

- Pay for blood clotting factors at ASP+5 percent and to continue our policy for payment of the furnishing fee using the updated amount for CY 2008.
- For CY 2008, the furnishing fee increases by 4.0 percent to \$0.158.

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OPPS Changes-Drugs, Pharmaceuticals & Biologicals

Payment for Radiopharmaceuticals

- For CYs 2006 and 2007, used mean unit cost data from hospital claims to determine each radiopharmaceutical's packaging status and implemented a temporary policy to pay for separately payable radiopharmaceuticals based on the hospital's charge for each radiopharmaceutical adjusted to cost.

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OPPS Changes-Drugs, Pharmaceuticals & Biologicals

Payment for Radiopharmaceuticals

- For CY 2008, CMS made separate payment proposals for diagnostic radiopharmaceuticals and therapeutic radiopharmaceuticals.
- CY 2008 OPPS/ASC proposed rule to package payment for diagnostic radiopharmaceuticals and contrast agents with per day costs over \$60 as part of our packaging proposal for CY 2008.

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OPPS Changes-Drugs, Pharmaceuticals & Biologicals

Payment for Diagnostic Radiopharmaceuticals

- Final payment policy of packaging payment for diagnostic radiopharmaceuticals and contrast agents and provide payment for these products through payment for their associated procedures.

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OPPS Changes-Drugs, Pharmaceuticals & Biologicals

Payment for Therapeutic Radiopharmaceuticals

- For CY 2008, CMS proposed to continue separate payment for therapeutic radiopharmaceuticals that have a mean per day cost of more than \$60, consistent with the packaging methodology applied to other nonpass-through drugs and biologicals.

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OPPS Changes-Drugs, Pharmaceuticals & Biologicals

Payment for Therapeutic Radiopharmaceuticals

HCPCS Code	Short Descriptor	Final CY 2008 APC	Final CY 2008 SI	Final CY 2008 Payment Rate
A9517	I131 iodide cap, rx	1064	K	\$15.24
A9530	I131 iodide sol, rx	1150	K	\$11.22
A9543	Y90 ibritumomab, rx	1643	K	\$15,023.91
A9545	I131 tositumomab, rx	1645	K	\$11,264.25
A9563	P32 Na phosphate	1675	K	\$113.60
A9564	P32 chromic phosphate	1676	K	\$119.18
A9600	Sr89 strontium	0701	K	\$612.06
A9605	Sm 153 lexidronm	0702	K	\$1,361.07

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OPPS Changes-Drugs, Pharmaceuticals & Biologicals

Payment for Nonpass-Through Drugs, Biologicals, and Radiopharmaceuticals with HCPCS Codes, but without OPPS Hospital Claims Data

- Provide payment for these new drugs and biologicals with HCPCS codes as of Jan 1, 2008, but which do not have pass-through status and are without OPPS hospital claims data, at ASP+5 percent, consistent with our final payment methodology for other separately payable nonpass-through drugs and biologicals.
- Assign status indicator “K” to HCPCS codes for new drugs and biologicals for which we have not received a pass-through application.

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OPPS Changes-Drugs, Pharmaceuticals & Biologicals

TABLE 32.—NEW CY 2008 HCPCS CODES FOR DRUGS, BIOLOGICALS, AND RADIOPHARMACEUTICALS

Table 33 lists all of the nonpass-through drugs and biologicals without available CY 2006 claims data to which these final policies would apply in CY 2008.

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OPPS Changes-Drugs, Pharmaceuticals & Biologicals --- Table 33

HCPDS Code	Short Descriptor	ASP-Based Payment Rate	Estimated Average Number of Units Per Administration	Final CY 2008 SI	CY 2008 APC
J0288	Amoxicillin trihydrate	\$11.89	35	E	0733
J0504	Amoxicillin hydrochloride		6	N	
J1334	Enfemotide injection	\$0.40	100	E	0767
J2170	Mecasermin injection	\$15.62	15.6	E	0805
J2315	Polinacron, depot form	\$1.87	300	E	0759
J5355	Urofollitropin, 75 iu	\$10.22	2	E	1341
J8050	Naloxone oral	\$16.89	6	E	0808

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OPPS Changes-Drugs, Pharmaceuticals & Biologicals

TABLE 34.—PREVIOUSLY UNRECOGNIZED HCPDS CODES AND STATUS INDICATORS FOR CY 2008

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Table 34

HCPCS Code, Nonly Replaced in CY 2008	Administered HCPCS Code	Final CY 2008 SI	HCPCS Code, Nonly Replaced in CY 2008	Administered HCPCS Code	Final CY 2008 SI
J1460	J1460	N	J1460	J1460	N
J1461	J1461	N	J1461	J1461	N
J1462	J1462	N	J1462	J1462	N
J1463	J1463	N	J1463	J1463	N
J1464	J1464	N	J1464	J1464	N
J1465	J1465	N	J1465	J1465	N
J1466	J1466	N	J1466	J1466	N
J1467	J1467	N	J1467	J1467	N
J1468	J1468	N	J1468	J1468	N
J1469	J1469	N	J1469	J1469	N
J1470	J1470	N	J1470	J1470	N
J1471	J1471	N	J1471	J1471	N
J1472	J1472	N	J1472	J1472	N
J1473	J1473	N	J1473	J1473	N
J1474	J1474	N	J1474	J1474	N
J1475	J1475	N	J1475	J1475	N
J1476	J1476	N	J1476	J1476	N
J1477	J1477	N	J1477	J1477	N
J1478	J1478	N	J1478	J1478	N
J1479	J1479	N	J1479	J1479	N
J1480	J1480	N	J1480	J1480	N
J1481	J1481	N	J1481	J1481	N
J1482	J1482	N	J1482	J1482	N
J1483	J1483	N	J1483	J1483	N
J1484	J1484	N	J1484	J1484	N
J1485	J1485	N	J1485	J1485	N
J1486	J1486	N	J1486	J1486	N
J1487	J1487	N	J1487	J1487	N
J1488	J1488	N	J1488	J1488	N
J1489	J1489	N	J1489	J1489	N
J1490	J1490	N	J1490	J1490	N
J1491	J1491	N	J1491	J1491	N
J1492	J1492	N	J1492	J1492	N
J1493	J1493	N	J1493	J1493	N
J1494	J1494	N	J1494	J1494	N
J1495	J1495	N	J1495	J1495	N
J1496	J1496	N	J1496	J1496	N
J1497	J1497	N	J1497	J1497	N
J1498	J1498	N	J1498	J1498	N
J1499	J1499	N	J1499	J1499	N
J1500	J1500	N	J1500	J1500	N
J1501	J1501	N	J1501	J1501	N
J1502	J1502	N	J1502	J1502	N
J1503	J1503	N	J1503	J1503	N
J1504	J1504	N	J1504	J1504	N
J1505	J1505	N	J1505	J1505	N
J1506	J1506	N	J1506	J1506	N
J1507	J1507	N	J1507	J1507	N
J1508	J1508	N	J1508	J1508	N
J1509	J1509	N	J1509	J1509	N
J1510	J1510	N	J1510	J1510	N
J1511	J1511	N	J1511	J1511	N
J1512	J1512	N	J1512	J1512	N
J1513	J1513	N	J1513	J1513	N
J1514	J1514	N	J1514	J1514	N
J1515	J1515	N	J1515	J1515	N
J1516	J1516	N	J1516	J1516	N
J1517	J1517	N	J1517	J1517	N
J1518	J1518	N	J1518	J1518	N
J1519	J1519	N	J1519	J1519	N
J1520	J1520	N	J1520	J1520	N
J1521	J1521	N	J1521	J1521	N
J1522	J1522	N	J1522	J1522	N
J1523	J1523	N	J1523	J1523	N
J1524	J1524	N	J1524	J1524	N
J1525	J1525	N	J1525	J1525	N
J1526	J1526	N	J1526	J1526	N
J1527	J1527	N	J1527	J1527	N
J1528	J1528	N	J1528	J1528	N
J1529	J1529	N	J1529	J1529	N
J1530	J1530	N	J1530	J1530	N
J1531	J1531	N	J1531	J1531	N
J1532	J1532	N	J1532	J1532	N
J1533	J1533	N	J1533	J1533	N
J1534	J1534	N	J1534	J1534	N
J1535	J1535	N	J1535	J1535	N
J1536	J1536	N	J1536	J1536	N
J1537	J1537	N	J1537	J1537	N
J1538	J1538	N	J1538	J1538	N
J1539	J1539	N	J1539	J1539	N
J1540	J1540	N	J1540	J1540	N
J1541	J1541	N	J1541	J1541	N
J1542	J1542	N	J1542	J1542	N
J1543	J1543	N	J1543	J1543	N
J1544	J1544	N	J1544	J1544	N
J1545	J1545	N	J1545	J1545	N
J1546	J1546	N	J1546	J1546	N
J1547	J1547	N	J1547	J1547	N
J1548	J1548	N	J1548	J1548	N
J1549	J1549	N	J1549	J1549	N
J1550	J1550	N	J1550	J1550	N
J1551	J1551	N	J1551	J1551	N
J1552	J1552	N	J1552	J1552	N
J1553	J1553	N	J1553	J1553	N
J1554	J1554	N	J1554	J1554	N
J1555	J1555	N	J1555	J1555	N
J1556	J1556	N	J1556	J1556	N
J1557	J1557	N	J1557	J1557	N
J1558	J1558	N	J1558	J1558	N
J1559	J1559	N	J1559	J1559	N
J1560	J1560	N	J1560	J1560	N
J1561	J1561	N	J1561	J1561	N
J1562	J1562	N	J1562	J1562	N
J1563	J1563	N	J1563	J1563	N
J1564	J1564	N	J1564	J1564	N
J1565	J1565	N	J1565	J1565	N
J1566	J1566	N	J1566	J1566	N
J1567	J1567	N	J1567	J1567	N
J1568	J1568	N	J1568	J1568	N
J1569	J1569	N	J1569	J1569	N
J1570	J1570	N	J1570	J1570	N
J1571	J1571	N	J1571	J1571	N
J1572	J1572	N	J1572	J1572	N
J1573	J1573	N	J1573	J1573	N
J1574	J1574	N	J1574	J1574	N
J1575	J1575	N	J1575	J1575	N
J1576	J1576	N	J1576	J1576	N
J1577	J1577	N	J1577	J1577	N
J1578	J1578	N	J1578	J1578	N
J1579	J1579	N	J1579	J1579	N
J1580	J1580	N	J1580	J1580	N
J1581	J1581	N	J1581	J1581	N
J1582	J1582	N	J1582	J1582	N
J1583	J1583	N	J1583	J1583	N
J1584	J1584	N	J1584	J1584	N
J1585	J1585	N	J1585	J1585	N
J1586	J1586	N	J1586	J1586	N
J1587	J1587	N	J1587	J1587	N
J1588	J1588	N	J1588	J1588	N
J1589	J1589	N	J1589	J1589	N
J1590	J1590	N	J1590	J1590	N
J1591	J1591	N	J1591	J1591	N
J1592	J1592	N	J1592	J1592	N
J1593	J1593	N	J1593	J1593	N
J1594	J1594	N	J1594	J1594	N
J1595	J1595	N	J1595	J1595	N
J1596	J1596	N	J1596	J1596	N
J1597	J1597	N	J1597	J1597	N
J1598	J1598	N	J1598	J1598	N
J1599	J1599	N	J1599	J1599	N
J1600	J1600	N	J1600	J1600	N
J1601	J1601	N	J1601	J1601	N
J1602	J1602	N	J1602	J1602	N
J1603	J1603	N	J1603	J1603	N
J1604	J1604	N	J1604	J1604	N
J1605	J1605	N	J1605	J1605	N
J1606	J1606	N	J1606	J1606	N
J1607	J1607	N	J1607	J1607	N
J1608	J1608	N	J1608	J1608	N
J1609	J1609	N	J1609	J1609	N
J1610	J1610	N	J1610	J1610	N
J1611	J1611	N	J1611	J1611	N
J1612	J1612	N	J1612	J1612	N
J1613	J1613	N	J1613	J1613	N
J1614	J1614	N	J1614	J1614	N
J1615	J1615	N	J1615	J1615	N
J1616	J1616	N	J1616	J1616	N
J1617	J1617	N	J1617	J1617	N
J1618	J1618	N	J1618	J1618	N
J1619	J1619	N	J1619	J1619	N
J1620	J1620	N	J1620	J1620	N

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OPPS Changes-Drugs, Pharmaceuticals & Biologicals

TABLE 35.—DRUGS AND BIOLOGICALS WITHOUT INFORMATION ON PER DAY COST THAT ARE PACKAGED IN CY 2008

HCPCS Code	Short Descriptor	Final CY 2008 SI
90393	Vaccina ig, im	N
90477	Adenovirus vaccine, type 7	N
90581	Anthrax vaccine, sc	N
90727	Plague vaccine, im	N
J0395	Arbutamine HCl injection	N
J1452	Intraocular Fomivirsena	N

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OPPS Changes-Drugs, Pharmaceuticals & Biologicals

TABLE 96—CY 2008 DEVICES WITH CURRENT PASS-THROUGH CATEGORIES CONTINUING INTO CY 2008

HCPCS Code	APC	Current Pass-Through Device Category
C1021	1821	Intergroup proton distraction device (implantable)
T8090	1057	Auditory co-integrated device, includes all internal and external components

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OPPS Payment for Brachytherapy Sources

- Three sources that are currently available in stranded and non-stranded forms: iodine-125; palladium-103; and cesium-131 (72 FR 42746).
- Created six new HCPCS codes to differentiate the stranded and non-stranded versions of these three sources. These six new HCPCS codes replaced the three prior brachytherapy source HCPCS codes for iodine, palladium and cesium (C1718, C1720, and C2633, all of which were deleted as of July 1, 2007), respectively, effective July 1, 2007.

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OPPS Payment for Brachytherapy Sources

- Pay brachytherapy sources prospectively for CY 2008, based on median costs from our CY 2006 claims data.
- For stranded sources, that median cost is set at the 60th percentile of the aggregate claims data for the predecessor code for this source
- For non-stranded sources, that median cost is set at the 40th percentile of the aggregate claims data for the predecessor code for this source.
- The final brachytherapy source HCPCS codes, APC assignments, status indicators, and median costs are displayed in Table 37 below.

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Table 37

HCPCS Code	Long Description	APC	CY 2008 Median Cost	CY 2008 Status Indicator
A6527	Iodine I-125, sodium iodide solution, therapeutic, per milligram	2602	\$27	K
C1718	Brachytherapy source, non-stranded, Gold-198, per source	1718	\$52	K
C1717	Brachytherapy source, non-stranded, High Dose Rate Iridium-192, per source	1717	\$173	K
C1719	Brachytherapy source, non-stranded, Non-High Dose Rate Iridium-192, per source	1719	\$84	K
C1816	Brachytherapy source, non-stranded, Yttrium-90, per source	2616	\$11,603	K
C1814	Brachytherapy source, non-stranded, High Activity, Iodine-125, greater than 1.01 mCi (30.27), per source	2604	\$51	K
C1815	Brachytherapy source, non-stranded, High Activity, Palladium-103, greater than 2.1 mCi (59.27), per source	2605	\$46	K
C1818	Brachytherapy linear source, non-stranded, Palladium-103, per 12.5cm	2608	\$42	K
C1817	Brachytherapy source, non-stranded, Ytterbium-169, per source	2607	NA	D
C1813	Brachytherapy source, stranded, Iodine-125, per source	2603	**81	K
C1819	Brachytherapy source, non-stranded, Iodine-125, per source	2609	**12	K
C1840	Brachytherapy source, stranded, Palladium-103, per source	2640	**81	K
C1841	Brachytherapy source, non-stranded, Palladium-103, per source	2641	**51	K
C1842	Brachytherapy source, stranded, Cesium-137, per source	2642	**97	K
C1843	Brachytherapy source, non-stranded, Cesium-137, per source	2643	**83	K
C1802	Brachytherapy source, stranded, not otherwise specified, per source	2682	\$45	K
C1803	Brachytherapy source, non-stranded, not otherwise specified, per source	2683	\$51	K

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OPPS Drug Administration Coding and Payment

- From the start of the OPSS until the end of CY 2004, three HCPCS codes (Q0081, Q0083, Q0084) were used to bill drug administration services provided in the hospital outpatient department.
- Another HCPCS code (Q0085) was used until the end of CY 2003

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OPPS Drug Administration Coding and Payment

- In 2005, OPSS transitioned to the use of CPT codes for drug administration services.
- For CY 2006, CMS implemented 20 of the 33 CY 2006 drug administration CPT codes that did not reflect the concepts of initial, sequential, and concurrent services, and created 6 new HCPCS C-codes that generally paralleled the CY 2005 CPT codes for the same services.

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OPPS Drug Administration Coding and Payment

- For CY 2007, implemented the full set of CPT codes, including the concepts of initial, sequential and concurrent.
- Assigned all CY 2007 HCPCS codes for drug administration services to six new drug administration APCs

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OPPS Drug Administration Coding and Payment

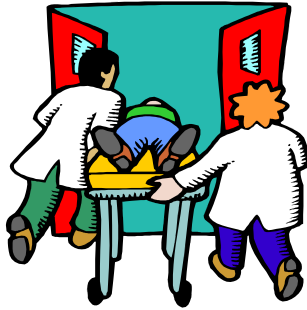
- For CY 2008, finalized proposed exception to the 2 times rule for APC 0438.
- Report all CPT drug administration codes, and indicated that we expect hospitals to report CPT codes consistently with CPT coding guidelines and applicable instructions.
- Recognize all active CY 2008 CPT codes for drug administration services under the CY 2008 OPSS.
- Assign status indicator "N" to CPT code 90768 for CY 2008.

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Hospital Coding & Payment For Visits

EMERGENCY



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Hospital Coding & Payments for Visits

- CMS instructed hospitals to use the CY 2007 CPT codes, as well as six HCPCS codes that became effective January 1, 2007, to report clinic and emergency department visits, and critical care services on claims paid under the OPPS.
- The codes are listed below in Table 38.
- These codes are unchanged for CY 2008.

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Table 38

TABLE 38.—CY 2007 CPT EVALUATION AND MANAGEMENT (E/M) AND LEVEL II HCPCS CODES USED TO REPORT CLINIC AND EMERGENCY DEPARTMENT VISITS

Clinic Visit HCPCS Codes	
HCPCS Code	Descriptor
99201	Office or other outpatient visit for the evaluation and management of a new patient (Level 1)
99202	Office or other outpatient visit for the evaluation and management of a new patient (Level 2)
99203	Office or other outpatient visit for the evaluation and management of a new patient (Level 3)
99204	Office or other outpatient visit for the evaluation and management of a new patient (Level 4)
99205	Office or other outpatient visit for the evaluation and management of a new patient (Level 5)
99211	Office or other outpatient visit for the evaluation and management of an established patient (Level 1)
99212	Office or other outpatient visit for the evaluation and management of an established patient (Level 2)
99213	Office or other outpatient visit for the evaluation and management of an established patient (Level 3)
99214	Office or other outpatient visit for the evaluation and management of an established patient (Level 4)
99215	Office or other outpatient visit for the evaluation and management of an established patient (Level 5)
99241	Office consultation for a new or established patient (Level 1)
99243	Office consultation for a new or established patient (Level 3)
99244	Office consultation for a new or established patient (Level 4)
99245	Office consultation for a new or established patient (Level 5)

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Table 38

Emergency Department Visit HCPCS Codes

HCPCS Code	Descriptor
99281	Emergency department visit for the evaluation and management of a patient (Level 1)
99282	Emergency department visit for the evaluation and management of a patient (Level 2)
99283	Emergency department visit for the evaluation and management of a patient (Level 3)
99284	Emergency department visit for the evaluation and management of a patient (Level 4)
99285	Emergency department visit for the evaluation and management of a patient (Level 5)
G0380	Type B emergency department visit (Level 1)
G0381	Type B emergency department visit (Level 2)
G0382	Type B emergency department visit (Level 3)
G0383	Type B emergency department visit (Level 4)
G0384	Type B emergency department visit (Level 5)

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Table 38

Critical Care Services HCPCS Codes	
HCPCS Code	Descriptor
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes
99292	Each additional 30 minutes
G0390	Trauma response associated with hospital critical care services

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Table 39 E/M Hospital Clinic Level 1

TABLE 39.--PROPOSED RULE ASSIGNMENT OF CLAIMS DATA FROM CY 2006 CPT E/M LEVEL II HCPCS CODES TO VISIT APCs FOR CY 2008

CY 2008 APC Title	CY 2008 APC	Proposed CY 2008 APC Median	APC Service Frequency (in million)	HCPCS Code	Short Descriptor
Level 1 Hospital Clinic Visits	0604	\$52.72	3.8	92012	Eye exam established pat
				99201	Office/outpatient visit, new (Level 1)
				99211	Office/outpatient visit, est (Level 1)
				99241	Office consultation (Level 1)
				G0101	CA screen; pelvic/breast exam
				G0245	Initial foot exam pt lops
				G0379	Direct admit hospital observ

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Table 39 E/M Hospital Clinic Level 2

Level 2 Hospital Clinic Visits	0605	\$63.01	7.3	90862	Medication management
				92002	Eye exam, new patient
				92014	Eye exam and treatment
				99202	Office/outpatient visit, new (Level 2)
				99212	Office/outpatient visit, est (Level 2)
				99213	Office/outpatient visit, est (Level 3)
				99242	Office Consultation (Level 2)
				99243	Office Consultation (Level 3)
				99431	Initial care, normal newborn
				G0246	Followup eval of foot pt lop
				G0344	Initial preventive exam
				M0064	Visit for drug monitoring

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Table 39 E/M Hospital Clinic Level 3

Level 3 Hospital Clinic Visits	0606	\$85.96	2.9	92004	Eye exam, new patient
				99203	Office/outpatient visit, new (Level 3)
				99214	Office/outpatient visit, est (Level 4)
				99244	Office consultation (Level 4)

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Table 39 E/M Hospital Clinic Level 4&5

Level 4 Hospital Clinic Visits	0607	\$108.08	.8	99204	Office/outpatient visit, new (Level 4)
				99215	Office/outpatient visit, est (Level 5)
				99245	Office consultation (Level 5)
Level 5 Hospital Clinic Visits	0608	\$138.88	.08	99205	Office/outpatient visit, new (Level 5)
				G0175	OPPS service, sched team conf

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Table 40 CY 2008 Proposed Median Costs of New and Established Pt Visits

TABLE 40.—CY 2008 PROPOSED MEDIAN COSTS OF NEW AND ESTABLISHED PATIENT VISIT CPT CODES

Clinic Visit Level	CY 2008 New Patient Visit Proposed Median Cost	CY 2008 Established Patient Visit Proposed Median Cost
Level 1	\$56.08	\$50.70
Level 2	\$63.18	\$58.84
Level 3	\$74.99	\$64.73
Level 4	\$109.12	\$84.17
Level 5	\$138.06	\$102.89

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New and Established Pt Clinic Visits

- For CY 2008, CMS finalized to continue to recognize the CPT codes for new and established patient clinic visits under the OPPS, consistent with their CPT code descriptors.
- Mapping the CPT E/M codes and other Level II HCPCS to the appropriate Clinic Visit APCs, based on resource costs.
- Addendum B to this final rule with comment period for the complete listing of visit codes and their placements for CY 2008.

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TABLE 42.—CY 2008 MEDIAN COSTS AND FREQUENCIES OF CPT CONSULTATION VISIT CODES USING CY 2006 PROPOSED RULE DATA

Level 1 Consultation	\$66.48	62,000
Level 2 Consultation	\$65.78	73,000
Level 3 Consultation	\$81.95	155,000
Level 4 Consultation	\$109.96	176,000
Level 5 Consultation	\$139.61	94,000

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Consultation codes

- Changed the status of the consultation codes so that these codes are no longer recognized for payment under the OPSS.

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Emergency Department Visits

TABLE 43.—CY 2007 FINAL LEVEL II HCPCS CODES TO BE USED TO REPORT EMERGENCY DEPARTMENT VISITS PROVIDED IN TYPE B EMERGENCY DEPARTMENTS (G0380, G0381, G0382, G0383, G0384)

TABLE 44.—CY 2008 FINAL LEVEL II HCPCS CODES TO BE USED TO REPORT EMERGENCY DEPARTMENT VISITS PROVIDED IN TYPE B EMERGENCY DEPARTMENTS (G0380, G0381, G0382, G0383, G0384) modifying the long descriptors

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Emergency Department Visits

- Finalized CY 2008 proposal to pay for Type A emergency department visits at the five Emergency Department Visit APC rates, while Type B emergency department visits will continue to be paid based on the five Clinic Visit APCs.

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Visit Reporting Guidelines

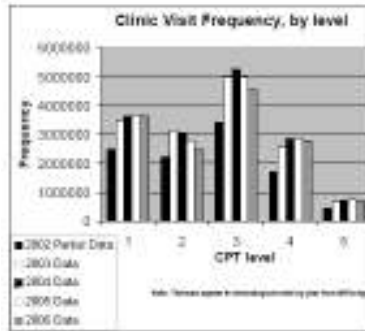
- August 9, 2002 OPPS proposed rule (67 FR 52133), we proposed 10 new G-codes (Levels 1-5 Facility Emergency Services and Levels 1-5 Facility Clinic Services) for use in the OPPS to report hospital visits, with the goal of ultimately applying national guidelines to these codes and discontinuing the use of CPT E/M codes under the OPPS.
- In response to comments, in the November 1, 2002 OPPS final rule (67 FR 66793), CMS stated that we would not create new codes to replace existing CPT E/M codes for reporting hospital visits until national guidelines are developed.

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CY 2007 Work on Visit Guidelines

Figure 1—Frequency Distribution of New and Established Patient Clinic Visits, by Level of Code

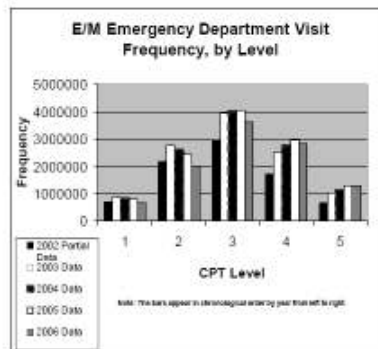


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Frequency Distribution ED Visits

Figure 2—Frequency Distribution of Emergency Department Visits, by Level of Code



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E/M National Guidelines

- Did not propose to implement national visit guidelines for clinic or emergency department visits for CY 2008.
- Instead, hospitals would continue to report visits during CY 2008 according to their own internal hospital guidelines.

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E/M Guidelines

Expectation that hospitals' internal guidelines would comport with the principles listed below:

- (1) The coding guidelines should follow the intent of the CPT code descriptor in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the code (65 FR 18451).
- (2) The coding guidelines should be based on hospital facility resources. The guidelines should not be based on physician resources (67 FR 66792).
- (3) The coding guidelines should be clear to facilitate accurate payments and be usable for compliance purposes and audits (67 FR 66792).
- (4) The coding guidelines should meet the HIPAA requirements (67 FR 66792).
- (5) The coding guidelines should only require documentation that is clinically necessary for patient care (67 FR 66792).
- (6) The coding guidelines should not facilitate upcoding or gaming (67 FR 66792).

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E/M Guidelines

Following five additional principles for application to hospital-specific guidelines:

- (7) The coding guidelines should be written or recorded, well-documented, and provide the basis for selection of a specific code.
- (8) The coding guidelines should be applied consistently across patients in the clinic or emergency department to which they apply.
- (9) The coding guidelines should not change with great frequency.
- (10) The coding guidelines should be readily available for fiscal intermediary (or, if applicable, MAC) review.
- (11) The coding guidelines should result in coding decisions that could be verified by other hospital staff, as well as outside sources.

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Blood and blood products

- Since the implementation of the OPPS in August 2000, separate payments have been made for blood and blood products through APCs rather than packaging them into payments for the procedures with which they were administered.
- For CY 2008, established payment rates for blood and blood products by using the same simulation methodology described in the November 15, 2004 final rule with comment period (69 FR 65816), which utilizes hospital-specific actual or simulated CCRs for blood cost centers to convert hospital charges for blood and blood products to costs.

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Blood and blood products

- Under this final policy, we expect that payments would increase for approximately 77 percent of blood and blood product units if patterns of furnishing blood products in CY 2008 remain similar to those in CY 2006.
- **TABLE 45.—CY 2008 MEDIAN COSTS FOR BLOOD AND BLOOD PRODUCTS**

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Observation Services 2007

- Since January 1, 2006, hospitals have reported observation services based on an hourly unit of care using HCPCS code G0378 (Hospital observation services, per hour).
- This code has a status indicator of “Q” under the CY 2007 OPPS.
- CY 2007, the beneficiary must have one of three medical conditions: congestive heart failure (CHF), chest pain, or asthma.

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Observation Services 2007

- CY 2007, the claim for observation services must include one of the following services in addition to the reported observation services. The additional services listed below must have a line item date of service on the same day or the day before the date reported for observation:
 - An emergency department visit (APC 0609, 0613, 0614, 0615, or 0616); or
 - A clinic visit (APC 0604, 0605, 0606, 0607, or 0608); or
 - Critical care (APC 0617); or
 - Direct admission to observation reported with HCPCS code G0379 (APC 0604).

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Observation Services G0278 CY 2008

- Adopting proposal to package payment for observation care reported with HCPCS code G0378 for CY 2008, with a modification to establish two new composite APCs for extended assessment and management.
- For CY 2008, payment for observation services reported with HCPCS code G0378 will remain packaged with status indicator "N."

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Observation Services G0378 CY 2008

- Creating two composite APCs for extended assessment and management, of which observation care is a component.
- In addition, NOT require a qualifying diagnosis for composite APC payment, but for the purposes of composite APC payment, will retain all other criteria, including a minimum number of eight hours; a qualifying visit, direct admission, or critical care; and no “T” status procedure reported on the day before or day of observation services.

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Observation Services G0379 CY 2008

- CY 2008 payment for HCPCS code G0379, direct admission for hospital observation care, will be made either through composite APC 8002 (Level I Extended Assessment and Management Composite) or APC 0604 (Level 1 Hospital Clinic Visits). In cases where the criteria for payment under either APC are not met, HCPCS code G0379 is assigned status indicator “N.”

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Procedures That Will Be Paid Only as Inpatient Procedures

- Removed 13 procedures from the OPPI inpatient list for CY 2008 and to assign them to clinically appropriate APCs as shown in Table 46 below.

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Removal from Inpt Procedure List – Table 46

TABLE 46.—HCPCS CODES FOR REMOVAL FROM INPATIENT LIS AND THEIR APC ASSIGNMENTS FOR CY 2008

HCPCS Code	Long Descriptor	CY 2008 APC	CY 2008 SI
21360	Open treatment of depressed malar fracture, including zygomatic arch and malar tripod	0254	I
21365	Open treatment of complicated (eg, comminuted or involving cranial nerve foramina) fracture(s) of malar area, including zygomatic arch and malar tripod, with internal fixation and multiple surgical approaches	0256	I
21385	Open treatment of orbital floor blowout fracture; transnasal approach (Caldwell-Luc type operation)	0256	I
25931	Transmetacarpal amputation, re-amputation	0049	I
27006	Tenotomy, abductors and/or extensor(s) of hip, open (separate procedure)	0050	I
27720	Repair of nonunion or malunion, tibia; without graft, (eg, compression technique)	0063	I
27722	Repair of nonunion or malunion, tibia; with sliding graft	0064	I

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Removal from Inpt Procedure List – Table 46 (con't)

HCPCS Code	Long Descriptor	CY 2008 APC	CY 2008 SI
50580	Rectal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus	0161	T
51535	Cystotomy for excision, incision, or repair of ureterocele	0162	T
58805	Drainage of ovarian cyst(s), unilateral or bilateral, (separate procedure); abdominal approach	0195	T
60271	Thyroidectomy, including substernal thyroid, cervical approach	0256	T
61770	Stereotactic localization, including burr hole(s), with insertion of catheter(s) or probe(s) for placement of radiation source	0221	T
69970	Removal of tumor, temporal bone	0256	T

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Outpatient Hospital Services and Supplies Incident to a Physician Service

- Finalized CY 2008 proposal to remove from both paragraphs (a)(1)(iii) and (f) of §410.27 the phrase “at a location (other than an RHC or an FQHC) that CMS designates as a department of a provider under §413.65 of this chapter.”
- In place of the deleted phrase, inserted the phrase “at a department of a provider, as defined in §413.65(a)(2) of this subchapter, that has provider-based status in relation to a hospital under §413.65 of this subchapter.”

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Interrupted Procedures

- Currently, when a procedure is interrupted after its initiation or the administration of anesthesia, hospitals append modifier -74 to the interrupted procedure, and the full OPPS payment for the procedure is made.
- In addition, when a procedure requiring anesthesia is discontinued after the beneficiary is prepared for the procedure and taken to the room where the procedure is to be performed, but before the administration of anesthesia, hospitals currently append modifier -73 (Discontinued outpatient procedure prior to anesthesia administration) to the discontinued procedure and receive 50 percent of the OPPS payment for the planned procedure.
- Hospitals also report modifier -52 to signify that a service that did not require anesthesia was partially reduced or discontinued at the physician's discretion. Modifier -52 is reported under the OPPS for a variety of types of interrupted services, such as radiology services.
- Under the OPPS, CMS applies a 50-percent reduction to the facility payment for interrupted procedures and services reported with modifier -52.

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Interrupted Procedures - 2008

1. Technical conforming change to the title of §419.44 by removing the word "surgical," in order to encompass all the procedures performed in HOPDs.
2. Changed the heading of §419.44(b) from "Terminated procedures" to "Interrupted procedures."
3. Further technical conforming changes to paragraphs (b)(1) and (b)(2) by removing the words "surgical" to encompass all the procedures performed in HOPDs.
4. Added a new paragraph (b)(3) to reflect the current policy of the application of a 50-percent reduction to the OPPS payment when a hospital reports modifier 52 for interrupted or discontinued services that do not require anesthesia.

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Reporting of Wound Care Services

- Hospitals would receive separate payment under the OPSS when they bill for wound care services described by CPT codes 97597, 97598, 97602, 97605, and 97606 that are furnished to hospital outpatients by individuals independent of a certified therapy plan of care.

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Reporting of Cardiac Rehabilitation Services - 2007

- Since the initiation of the OPSS, Medicare has paid for cardiac rehabilitation services in HOPDs using CPT code 93797 (Physician services for outpatient cardiac rehabilitation, without continuous ECG monitoring (per session)) and CPT code 93798 (Physician services for outpatient cardiac rehabilitation, with continuous ECG monitoring (per session)).
- Both codes are assigned status indicator "S" and are currently mapped to APC 0095 (Cardiac Rehabilitation) for payment.

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Reporting of Cardiac Rehabilitation Services - 2008

- Did NOT finalize proposal to establish two new G-codes for reporting cardiac rehabilitation services.
- Instead, will continue to use CPT codes 93797 and 93798 to report cardiac rehabilitation services under the CY 2008 OPSS. CPT codes 93797 and 93798 are assigned to APC 0095 (Cardiac Rehabilitation), with a CY 2008 median cost of approximately \$36 and status indicator "S."

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Reporting of Cardiac Rehabilitation Services - 2008

- Beginning in CY 2008, allow hospitals to report more than one unit of service per day if more than one cardiac rehabilitation session lasting at least 1 hour each is provided on the same day, but will monitor the claims data to ensure that utilization of cardiac rehabilitation services remains appropriate.

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Reporting of Bone Marrow and Stem Cell Processing Services

- Discontinued use of HCPCS codes G0265, G0266, and G0267 and recognize CPT codes 38207 through 38215 to report bone marrow and stem cell processing services under the OPSS.
- However, did not finalizing the APC assignments of these services as proposed.
- Instead, assigned CPT codes 38207, 38208 and 38209 for cryopreserving, thawing and washing bone marrow and stem cells to APC 0110, with a median cost of approximately \$214 and a status indicator of "S."
- In addition, assigned CPT codes 38210 through 38215, reported for depletion services of bone marrow and stem cells, to APC 0393, which is renamed "Hematologic Processing and Studies," with a median cost of approximately \$358 and a status indicator of "S."

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Reporting of Alcohol and/or Substance Abuse Assessment and Intervention Services

- CY 2008, created two parallel G-codes to allow for appropriate Medicare reporting and payment for alcohol and substance abuse assessment and intervention services that are not provided as screening services, but that are performed in the context of the diagnosis or treatment of illness or injury.
- The codes are HCPCS code G0396 (Alcohol and/or substance (other than tobacco) abuse structured assessment (eg, AUDIT, DAST) and brief intervention, 15 to 30 minutes); and HCPCS code G0397 (Alcohol and/or substance (other than tobacco) abuse structured assessment (eg, AUDIT, DAST) and intervention, greater than 30 minutes).

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Reporting of Alcohol and/or Substance Abuse Assessment and Intervention Services

- CPT codes 99408 and 99409 are assigned status indicator “E” for CY 2008 on an interim final basis under the OPSS, meaning that they will not be recognized for payment under the OPSS or any other Medicare payment system.
- HCPCS codes G0396 and G0397 are assigned status indicator “S.” They are assigned, on an interim final basis, with other health and behavioral assessment and intervention services to APC 0432 (Health and Behavioral Services).

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Quality Data Reporting Requirements under OPSS



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Quality Data Reporting

- Section 109(a) of the MIEA-TRHCA (Pub. L. 109-432) amended section 1833(t) of the Act by adding a new subsection (17) that affects the payment rate update applicable to OPSS payments for services furnished by hospitals in outpatient settings on or after January 1, 2009.
- New section 1833(t)(17)(A) of the Act, which applies to hospitals as defined under section 1886(d)(1)(B) of the Act, requires that hospitals that fail to report data required for the quality measures selected by the Secretary in the form and manner required by the Secretary under section 1833(t)(17)(B) of the Act will incur a reduction in their annual payment update factor by 2.0 percentage points.

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Quality Data Reporting

- CMS is statutorily required to establish a program under which hospitals will report data on the quality of hospital outpatient care using standardized measures of care in order to receive the full annual update to the OPSS payment rate, effective for payments beginning in CY 2009.
- Refer to the program established under these amendments as the Hospital Outpatient Quality Data Reporting Program (HOP QDRP).

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Quality Data Reporting

- For hospitals to receive the full OPSS payment update for services furnished in CY 2009, in the CY 2008 OPSS/ASC hospital outpatient settings are required to submit data on the following 7 measures, effective with hospital outpatient services furnished on or after April 1, 2008.
 - ED-AMI-1 - Aspirin at Arrival
 - ED-AMI-2 - Median Time to Fibrinolysis
 - ED-AMI-3 - Fibrinolytic Therapy Received Within 30 Minutes of Arrival
 - ED-AMI-4 - Median Time to Electrocardiogram (ECG)
 - ED-AMI-5 - Median Time to Transfer for Primary PCI
 - PQRI #20 Perioperative Care: Timing of Antibiotic Prophylaxis
 - PQRI #21 Perioperative Care: Selection of Prophylactic Antibiotic

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Quality Data Reporting

- Sought public comment on 30 additional measures, which have been identified as hospital outpatient-appropriate measures and are under consideration for inclusion in the HOP QDRP measure set, for CY 2010 or subsequent calendar years.
- List on pages 1104 – 1107
- None adopted at this time.

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Requirements for HOP QDRP for CY 2009 and Subsequent Calendar Years

- In order to participate in the HOP QDRP for CY 2009 and subsequent calendar years, hospitals must meet administrative, data collection and submission, and data validation requirements.
- Hospitals not participating in the program or that withdraw from the program will not receive the full OPPS payment rate update. Instead, in accordance with the law, those hospitals would receive a reduction of 2.0 percentage points in their updates for the affected payment year.

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Requirements for HOP QDRP for CY 2009 and Subsequent Calendar Years

- Changed the deadline for the Notice of Participation form to January 31, 2008.
- The initial submission will be for services furnished on or after April 1, 2008. The final submission date for the initial quarterly data for April – June 2008 services is November 1, 2008.

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Requirements for HOP QDRP for CY 2009 and Subsequent Calendar Years

- Requiring hospitals to meet the below outlined administrative, data collection, and submission requirements under the HOP QDRP for payment determinations affecting the CY 2009 payment update.
1. Administrative Requirements
 - a. Identify a QualityNet Exchange administrator who follows the registration process and submits the information through the CMS-designated contractor.

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Requirements for HOP QDRP for CY 2009 and Subsequent Calendar Years

Administrative Requirements (con't)

- b. Register with the QualityNet Exchange, regardless of the method used for data submission.
- c. Complete the Notice of Participation form. All hospitals must send the form to a CMS-designated contractor no later than January 31, 2008 for the CY 2009 HOP QDRP.

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Requirements for HOP QDRP for CY 2009 and Subsequent Calendar Years

2. Data collection and Submission Requirement
 - a. Collect data required for the finalized set of 7 measures
 - b. Submit the data according to a data submission schedule that will be available on the QualityNet Exchange Web site. HOP data will be submitted through the QualityNet Exchange secure Web site (<https://www.qnetexchange.org>).

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Requirements for HOP QDRP for CY 2009 and Subsequent Calendar Years

- c. Submit complete and accurate data. A “complete” submission is determined based on sampling criteria that will be published and maintained in a specifications manual.
 - d. Submit the aggregate numbers of outpatient episodes of care which were eligible for submission under the HOP QDRP beginning with the first reporting period (April-June 2008) forward.

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Requirements for HOP QDRP for CY 2009 and Subsequent Calendar Years

3. HOP QDRP Validation Requirements
 - a. not implementing a data validation requirement for data submitted for the April-June 2008 time period for the purposes of the CY 2009 annual payment update.

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References

All regulations can be found:

<http://www.gpoaccess.gov/fr/> and

<http://www.cms.hhs.gov/QuarterlyProviderUpdates/>

<http://www.cms.hhs.gov/HospitalOutpatientPPS/HORD/>

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