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OPPS UPDATES FOR CY 2009

In the November 18, 2008 ***Federal Register***, the Centers for Medicare and Medicaid Services (CMS) published final changes to the hospital APC-based outpatient prospective payment system (OPPS) for services provided on or after January 1, 2009. This final rule implements applicable statutory requirements as well as changes arising out of Medicare's continued experience with the APC payment system. Updates include changes to APC definitions and the conversion factor, APC weights, facility wage indices, and additional steps towards increased payment consolidation using composite APCs and conditional packaging. In addition, this final rule includes the first major step towards value-based purchasing of hospital outpatient services, mandating quality reporting requirements and associated financial penalties for services effective on or after January 1, 2009. This final rule also discusses other initiatives related to hospital-acquired conditions in the outpatient setting.

Since the publication of this final rule, CMS has released additional OPPS-related transmittals, software and data files. These updates, as well as updated versions of the Final Rule Addendums, are generally available on the CMS Web site. Other changes to the 2009 OPPS are based on the Medicare Improvements for Patients and Providers Act (MIPPA) passed in July of 2008.

Changes from the OPPS final rule and other related OPPS updates for calendar year (CY) 2009 are summarized below.

Note: *The November 18, 2008 final rule also includes changes to Medicare's APC-based Ambulatory Surgery Center (ASC) Prospective Payment System for 2009. These changes will be documented in a separate Ingenix Industry Insight.*

1. **COMPOSITE APCS – IMAGING:** For 2009, CMS is expanding its use of composite APCs, which provide a single payment for several independent services when they are furnished on the same date of service. Composite APCs are intended to establish APC payment rates for combinations or "bundles" of services that are frequently furnished together. This methodology will contribute to CMS' goal of providing payment for larger bundles of services and will create additional hospital incentives for efficiency and cost containment.

   CMS is assigning new payment status indicator "Q3" to every code that is a component of at least one composite APC. Q3 identifies services that may be paid either separately or as part of a composite APC, depending on other services present on the claim.

   Also, CMS is introducing new composite APCs for multiple imaging services. Previously, CMS had proposed a 50% discount for multiple imaging services in the same imaging family but this proposal was postponed for further study. For CY 2009, CMS is instead using the composite APC methodology to improve payment accuracy for imaging services, incorporating the lower marginal cost for multiple services within the same family. CMS has identified three separate OPPS imaging families based on treatment modality: 1) Ultrasound, 2) CT/CTA, and 3) MRI/MRA. These families are then further separated into imaging services performed with or without contrast, as mandated by statutory requirements. Multiple services from the same group that are provided on a single day will be reimbursed as one unit of the appropriate composite APC. In total, five new composite APCs are effective January 1, 2009 (listed below). All are assigned to payment status "S". HCPCS codes belonging to each group can be found in Table 8

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of the Final Rule. In each case, one eligible code is assigned to the composite APC and all other services in the same family are packaged.

- ***<u>Composite APC 8004 (Ultrasound)</u>:*** Composite APC 8004 is assigned and a single payment is made when multiple ultrasound imaging services are provided on the same service date.

- ***<u>Composite APC 8005 (CT and CTA without contrast)</u>:*** Composite APC 8005 is assigned and a single payment is made when multiple CT and CT angiography scans are provided without contrast on the same service date.

- ***<u>Composite APC 8006 (CT and CTA with contrast)</u>:*** Composite APC 8006 is assigned and a single payment is made when multiple CT and CT angiography scans are provided with a contrast agent on the same date of service. If a patient receives both a CT service with contrast *and a* CT service without contrast on the same day, then Composite APC 8006 would also be assigned and a single payment would be made.

- ***<u>Composite APC 8007 (MRI and MRA without contrast)</u>:*** Composite APC 8007 is assigned and a single payment is made when multiple magnetic resonance imaging or angiography services are provided without contrast on the same date of service.

- ***<u>Composite APC 8008 (MRI and MRA with contrast)</u>:*** Composite APC 8008 is assigned and a single payment is made when multiple magnetic resonance imaging or angiography services are provided with a contrast agent on the same service date. If a patient receives both a MRI/MRA service with contrast *and* MRI/MRA service without contrast on the same day, then Composite APC 8008 would also be assigned and a single payment would be made.

2. **<u>COMPOSITE APCS – MENTAL HEALTH SERVICES</u>:** For 2009, CMS continues to cap payment for specific mental health services at the per diem partial hospitalization rate. This cap is implemented via Mental Health Composite APC 0034. Composite APC 0034 is assigned to a group of eligible mental health services when the total payment for those services exceeds the partial hospitalization per diem rate. Prior to 2009, this per diem rate was identified by the partial hospitalization APC 0033. For 2009, CMS is creating two new partial hospitalization APCs: 0172 and 0173 (see below). Composite APC 0034 will now be assigned to a group of mental health services when total payment for those services exceeds the rate associated with new APC 0173 (Level II Partial Hospitalization, four or more PHP services). Additionally, the payment status indicator for APC 0034 is changed from “P” to “S”, effective January 1, 2009.

3. **<u>CONDITIONAL PACKAGING</u>:** For 2009, CMS is expanding its list of services that are eligible for conditional packaging. Conditionally packaged services can be either packaged or separately payable, depending on what other services are present on the claim. The following two types of conditionally packaged services are being updated:

   - ***<u>T-packaged</u>*:** Services that are packaged if there is at least one service with payment status “T” on the same date;

   - ***<u>STVX-packaged</u>*:** Services that are packaged if there is at least one service with payment status “S”, “T”, “V” or “X” on the same date.

   For both scenarios described above, if there are multiple conditionally packaged services on the same date and there is no appropriate payment status “S”, “T”, “V” or “X” service on the same date, then CMS will pay only one of the conditionally packaged services. CMS will select the service with the highest individual APC rate and will only pay for one unit of that service. All other conditionally packaged services on the same date will be packaged. For 2009, CMS is assigning T-packaged services to new payment status “Q2”, and STVX-packaged services to

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new payment status "Q1". Prior to 2009, conditionally packaged services were initially assigned to payment status "Q" and then reassigned to the appropriate payable payment status or to packaged payment status "N", where applicable. This logic has been updated for 2009 with the "Q1" and "Q2" payment status indicators being reassigned to the appropriate payable or packaged payment status indicators as part of the claims processing procedure.

4. **CHANGES TO APC GROUPS:** CMS is required to annually review and revise the APC groups for changes in medical practice, changes in technology, and the addition of new services. This review is conducted in consultation with an outside advisory panel. In addition, CMS ensures, with certain exceptions, that services within a single APC meet the "2 times rule". This rule requires that the median cost of the most expensive item or service within a group cannot be more than two times greater than the median cost of the least expensive item or service within the same group. APC revisions for 2009 conform, in general, to this statutory framework. Overall, there were 62 new APCs, 51 deleted APCs, and many changes to the contents and definitions of existing APCs. The most substantial changes were in the areas of genitourinary, nervous system, orthopedic, radiation therapy procedures as well as mental health services. These changes are described in detail in the OPPS final rule.

5. **RECALIBRATION OF APC WEIGHTS:** Weights for each APC can be found in Addendum A of the final rule. These weights were calculated using the most current Medicare outpatient claims data, which are for services delivered between January 1, 2007 and December 31, 2007. Using the same basic methodology as previous years, CMS calculated APC weights based on median hospital costs. For CY 2009, CMS is continuing to calculate APC weights using single procedure claims, but has expanded its definition of eligible claims and is working towards significantly expanding its database for weight calculation based on the composite APC changes described above.

6. **CONVERSION FACTOR UPDATE:** For CY 2009, the OPPS conversion factor is updated based on the hospital inpatient market basket increase of 3.6%, a budget neutrality adjustment for wage index, and other changes. The CY 2009 conversion factor is $66.059 for those hospitals meeting the quality reporting requirements, and $64.784 for those that have not yet met the quality reporting requirements (see below).

7. **APC PAYMENT RATES:** The national unadjusted payment rates for APCs can be found in Addendum A of the final rule. For most APCs, this payment rate is equal to the final CY 2009 conversion factor multiplied by the final CY 2009 scaled weight for the APC. Separately payable drug rates are generally based on average sales price (ASP) + 4%. Payment rates are updated quarterly and posted to the CMS Web site (*www.cms.hhs.gov/HospitalOutpatientPPS*).

8. **CO-PAYMENT UPDATES:** For CY 2009, per the Benefits Improvement and Protection Act of 2000, the national unadjusted co-payment for an APC cannot exceed 40% of the APC rate. In addition, the co-payment for an individual service cannot exceed the 2009 inpatient deductible of $1068. The CY 2009 co-payment amounts by APC can be found in Addendum A of the final rule.

9. **WAGE INDEX CHANGES:** CMS continues to adjust for geographic wage differences using the inpatient PPS (IPPS) wage index values. The IPPS wage index updates were first described in the FY 2009 Inpatient final rule and have subsequently been revised and re-released several times. Final FY 2009 inpatient wage index values, which are effective for the OPPS on January 1, 2009, are available on the CMS Web site. Inpatient wage index changes for FY 2009 are described in *Ingenix Industry Insight No. 468, Final Medicare Pricer Changes for FY 2009*. CMS continues to adjust 60% of the APC payment rates and co-payments by the appropriate inpatient wage index.

10. **PAYMENTS TO CERTAIN RURAL HOSPITALS:** The two types of payment adjustments that are available for rural hospitals are described below.

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- ***Hold Harmless Transitional Payments:*** On December 31, 2005, the hold harmless protection provided by Section 411 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) expired for rural hospitals that have 100 or fewer beds and that are not eligible for the Rural SCH adjustment (see below). Hold harmless protection for these rural hospitals was then reinstated by Section 5105 of the Deficit Reduction Act of 2005 (DRA) and then extended by the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008. This hold harmless provision applies only to certain outpatient department services furnished on or after January 1, 2006 and before January 1, 2010. For CY 2009, when the OPPS payment is less than the payment the provider would have received under the previous reasonable cost-based system, reimbursement to eligible small rural providers is increased by 85% of the difference between these two payments.

- ***Adjustment for Rural SCHs:*** CMS is continuing the 7.1% adjustment for rural sole community hospitals (SCHs) for CY 2009. This budget-neutral adjustment is applied to all services and procedures paid under the OPPS except for drugs, biologicals, brachytherapy sources and pass-throughs. This adjustment is applied before calculating outlier eligibility and coinsurance.

11. **OUTLIER PAYMENT CHANGES:** To qualify for an outlier payment in CY 2009, the cost of a service must exceed both 1.75 times the APC payment (no change from 2008) and the APC payment rate plus a fixed dollar threshold of $1,800 (up from $1,575 in 2008). For those services that qualify, CMS will pay 50% of the costs that exceed the threshold of 1.75 times the APC payment rate. Community Mental Health Center (CMHC) claims are subject to different outlier criteria, as explained below. For CY 2009, the following services continue to be excluded from outlier payments: separately payable drugs, biologicals and radiopharmaceuticals; brachytherapy sources; and pass-through devices. Please note that as a result of MIPPA, brachytherapy sources continue to be paid on a reasonable-cost basis so they are not eligible for outlier payments in CY 2009.

12. **PARTIAL HOSPITALIZATION PAYMENTS:** Community Mental Health Center (CMHC) claims, as well as hospital claims for partial hospitalization services (indicated with a condition code of 41), are subject to per diem payment under the OPPS. In 2008, to be eligible for the partial hospitalization per diem payment, patients had to receive at least three designated partial hospitalization services on a single day, one of which had to be a psychotherapy service. For claims meeting this requirement, CMS assigned APC 0033 (Partial Hospitalization) and paid a per diem rate of $206.16.

    For CY 2009, APC 0033 has been eliminated and replaced by two new APCs:

    0172: Level I Partial Hospitalization (3 qualifying services)
    0173: Level II Partial Hospitalization (4 or more qualifying services)

    If a patient receives three qualifying services on a single day (at least one psychotherapy plus two others), payment is made using APC 0172, with a national payment rate of $161.05. If a patient receives four or more qualifying services on a specific service date (at least one psychotherapy plus three others), payment is made using APC 0173, with a national payment rate of $204.78. CMS is revising the list of qualified services for the partial hospitalization benefit, adding several codes and removing others. The final list of qualified services is included in the final rule.

    In 2008, partial hospitalization claims containing one or more service days with fewer than three eligible services were suspended for payment, often resulting in costly payment delays for the facility. For 2009, CMS will not suspend these claims, but will simply deny payment for all partial hospitalization services on each day that does not meet the minimum three-service requirement.

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For CMHCs, the multiplier applied when calculating outlier eligibility in 2009 remains at 3.4 times the APC payment. CMHC claims will continue to receive an outlier adjustment of 50% of the difference between costs and the threshold of 3.4 times the APC payment. For CMHC outlier calculations, the $1,800 fixed dollar threshold does not apply.

13. **<u>Transitional Pass-Through Devices</u>:** The two device categories (payment status "H") that were eligible for pass-through payment in 2008, C1821 (*interspinous implant*) and L8690 *(aud osseo dev, int/ext comp*), are no longer eligible for pass-through payment in 2009. These two codes now have a payment status of "N" (Packaged/incidental service), and an APC of zero. These devices were previously assigned to the APCs 1821 (Interspinous Implant) and APC 1032 (Aud Osseo Dev, Int/Ext Comp), respectively. There are currently no approved pass-through device categories for 2009, although CMS will continue to review new applications.

14. **<u>Hospital Outpatient Clinic and E.R. Visits:</u>** For 2009, CMS is changing the definitions of "new" and "established" patients as they relate to the reporting of hospital outpatient visits under the OPPS. Beginning on January 1, 2009, a patient who has registered as an inpatient or outpatient of the hospital within three years prior to the visit would be considered an "established" patient. A patient who has never been registered as an inpatient or outpatient at the hospital, or has only been registered more than three years prior to the visit, would be considered a "new" patient. Also for 2009, CMS has decided to assign Level 1-4 emergency department visits at Type B hospitals (i.e. hospitals that do not provide fulltime 24X7 emergency coverage) to different APCs than the Type A hospitals (i.e. hospitals that do provide 24X7 emergency coverage). CMS also chose to assign the Level 5 Type B emergency visit to the same APC as the Level 5 Type A emergency visit. Additionally, the HCPCS code representing the Level 5 Type B emergency department visit, G0384, has been added to the list of codes eligible for Composite APC 8003, Level II Extended Assessment and Management.

15. **<u>Transitional Pass-Through Drugs and Biologicals</u>:** In 2009, 24 drugs will be eligible for pass-through status (payment status "G"). These drugs are documented in Table 24 of the final rule. Note that several drugs on this list have received new Level II HCPCS code assignments for 2009. Table 23 of the final rule contains the list of drugs and biologicals for which pass-through status expired on December 31, 2008. These drugs have all been reassigned to payment status "N" (Packaged/incidental service) or "K" (Non-pass-through drugs and biologicals).

16. **<u>Drugs, Biologicals and Radiopharmaceuticals Eligible for Separate Payment</u>:** For CY 2009, CMS is updating the threshold used to package drugs, biologicals and radiopharmaceuticals that are not new and do not have pass-through status. For CY 2009 this threshold will be $60. These higher cost drugs are assigned to separate payment status "K" APCs.

    - ***<u>Packaging Rule Exceptions</u>:*** CMS will continue to exempt from packaging the seven anti-hemetic products that are listed in Table 29 of the final rule. These drugs are an integral part of chemotherapy treatment and CMS wants to make sure that beneficiaries have access to the most effective anti-emetic. All seven anti-emetics, both injectible and oral, will be paid separately.

    - ***<u>Specified Covered Drugs</u>:*** For CY 2009, payment for covered outpatient drugs, biologicals and their associated pharmacy handling costs will continue to be set at ASP plus 4% (updated quarterly). Blood clotting factors will receive an additional furnishing fee of $0.164.

    - ***<u>Radiopharmaceuticals</u>:*** Based on MIPPA, CMS will continue to pay for applicable radiopharmaceuticals in 2009 using the hospital charges reduced to costs. CMS will determine costs using the hospital's overall cost-to-charge ratio. Radiopharmaceuticals continue to have a payment status of "H".

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17. **BRACHYTHERAPY PAYMENT:** Per the MMA, between January 1, 2004 and December 31, 2006, brachytherapy devices were paid charges adjusted to costs and were not eligible for outlier payments. In the 2007 final rule, CMS planned to change the payment status of brachytherapy sources from "H" to "K" and to make them eligible for outlier payments. However, the Tax Relief and Health Care Act of 2006 extended cost-based payment for brachytherapy source payments through 2007. For 2008, CMS again planned to switch the payment status of brachytherapy sources from "H" to "K" and to make them eligible for outlier payments. However, the Medicare, Medicaid and SCHIP Extension Act of 2007 extended cost-based reimbursement for brachytherapy sources until July 2008 and the MIPAA 2008 legislation extended cost-based reimbursement until January 1, 2010. Therefore, for 2009, brachytherapy sources will continue to be paid based on charges reduced to cost. These services are not eligible for outlier payments, are not subject to the 2% quality reduction, and are not eligible for the rural SCH 7.1% increase. Also for 2009, CMS has designated a new payment status indicator "U" to be applied to all brachytherapy source services. Therefore, these services will no longer be assigned to payment status "H".

18. **BLOOD AND BLOOD SERVICES:** CMS develops rates for blood and blood products using a blood-specific cost-to-charge ratio (CCR) methodology, which uses CCRs from hospital cost reports to convert hospital charges for blood and blood products to costs. CMS developed this methodology in 2006 in response to research indicating that use of an overall hospital CCR for blood products often resulted in underestimation of true hospitals costs. To facilitate and improve the accuracy of the calculation of median costs using this blood-specific CCR methodology, CMS has determined that blood and blood products should be separately identified using new payment status indicator "R". This new payment status indicator will also facilitate the application of the quality reductions described below.

19. **NEW PAYMENT STATUS INDICATORS:** The final list of payment status indicators for 2009 includes the following five new payment status indicators (also described above), as well as changes to the descriptions of several others. The current set of OPPS payment status indicators is available in Addendum D1 of the final rule.

    Q1: Conditionally STVX packaged services
    Q2: Conditionally T packaged services
    Q3: Eligible for composite APC
    R: Blood and blood products
    U: Brachytherapy sources

20. **REPORTING QUALITY DATA UNDER OPPS:** CMS has finalized its plans to expand the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program to the OPPS. This program has been used for the inpatient PPS (IPPS) since FY 2005 and currently requires hospitals to submit data on 30 quality measures. The annual IPPS update factor is reduced by 2.0% for those hospitals that do not report quality data. In CY 2009, CMS is implementing a similar 2.0% reduction to the OPPS conversion factor update for hospitals that do not meet the specific requirements of the CY 2009 OPPS RHQDAPU program, which is based on the reporting of the following seven outpatient-specific quality measures. Of the seven, the five ED-AMI measures capture the quality of care of adult patients with acute myocardial infarctions in hospital emergency departments. The remaining two measures address the selection and timely administration of prophylactic antibiotics to prevent surgical infection.

    ED-AMI1: Aspirin at arrival
    ED-AMI2: Median time to fibrinolysis
    ED-AMI3: Fibrinolytic therapy received within 30 minutes of arrival
    ED-AMI4: Median time to electrocardiogram (ECG)
    ED-AMI5: Median time to transfer for primary PCI
    PQRI#20: Perioperative care: timing of antiobiotic prophylaxis
    PQRI#21: Perioperative care: selection of perioperative antibiotic

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The final rule also finalizes four additional imaging efficiency measures for the CY 2010 OPPS update and discusses additional measures under consideration for 2011.

All services with the following payment status indicators will be subject to the 2% quality reduction, excluding the new technology APCs 1491-1574:

P: Partial hospitalization services
R: Blood and blood products
S: Significant procedures, not subject to discounting
T: Significant procedures, subject to discounting
V: Clinic or E.R. visit
X: Ancillary services

Separately payable drugs, radiopharmaceuticals, pass-through services and brachytherapy sources, fee schedule items, and other services paid at charges reduced to costs, are not subject to the quality reduction. Application of the 2% quality reduction will be mathematically equivalent to multiplying base payment and co-payment by a reporting ratio of 0.981. To calculate outlier payments, claims subject to the quality reduction would use the reduced reimbursement compared to costs.

CMS plans to make the outpatient quality data publicly available, similar to the inpatient quality data now available on the hospital compare Web site. CMS has not yet determined the site or content of the publicly available quality data for outpatient services. Reporting of this data will be addressed in the 2010 OPPS proposed rule.

21. **HEALTH CARE-ASSOCIATED CONDITIONS:** Medicare has initiated the Hospital-acquired Conditions (HAC) Program in the inpatient setting. Under this program, specific conditions acquired during a hospital stay are bypassed during DRG assignment potentially resulting in reduced reimbursement to the hospitals. Identification of hospital-acquired conditions on a claim is made possible through use of the new Present On Admission (POA) indicator which must now be reported for every diagnosis on an inpatient claim. CMS is investigating initiating a similar program in the outpatient setting called the Healthcare Associated Conditions Program (also abbreviated HAC). The final rule contains a lengthy discussion of the options CMS is considering including refinements of POA reporting for outpatient claims and various mechanisms to eliminate or reduce payment for services related to these conditions. CMS hopes to implement the new HAC program as soon as possible and does not plan to defer the new outpatient program until after the implementation of ICD-10, as many commenters have suggested.

22. **OVERALL IMPACT:** CMS estimates that Medicare OPPS payments in 2009 will increase by approximately $1.6 billion due to provisions in the final rule.

FOR FURTHER INFORMATION

If you have questions regarding these OPPS changes, please contact our Client Services Department at 1-800-999-DRGS (3747). Be sure to check the Ingenix Web site for up-to-date information and additional ***Industry Insights*** on coding issues. You will find ***Industry Insights*** under “News & Events” (***http://www.ingenix.com/News/Industnews/***).

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