

CY10 CMS OPPS Update

Audio Seminar/Webinar

December 10, 2009

Practical Tools for Seminar Learning

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Understand the Key Areas of Financial and Operational Impact

1

Agenda



- ◆ **Major changes and discussion items from the final rule**
 - Physician supervision requirements
 - New MIPPA-related coverage benefits
 - Drugs, biologicals, radiopharmaceuticals, brachytherapy, and blood products
- ◆ **General Financial Updates for 2010**
 - Conversion factor, hold-harmless, outliers, and the hospital quality initiative
 - Reclassification of HCPCS/CPT® codes and impact on APC payments
 - Packaging, composite APCs, and estimating financial impact

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Agenda

- ◆ **Round-up of other key items of interest**
 - **Drug administration (injections and infusion)**
 - **Evaluation and management codes**
 - **Observation services**
 - **Inpatient only list**
 - **Device related procedure APCs**
 - **Partial hospitalization**
- ◆ **Wrap-up and Q/A**

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Key Drivers of OPPS 2010 Changes

- ◆ **Provider input**
 - **Clear recognition of physician supervision and separately payable drug reimbursement concerns that were raised by hospitals and the industry**
- ◆ **MIPPA related new benefit categories**
- ◆ **Health reform**
 - **Fewer widespread changes finalized for 2010 than in previous years**
- ◆ **Value-based purchasing**
 - **Initiatives introduced in 2008 and 2009 continue; no new initiatives for 2010**
 - **CMS continues to discuss how it wants to create greater and greater payment bundles in order to create "efficiency incentives" for hospitals**

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Key Changes and Discussion Items from the 2010 OPPS Final Rule

- ◆ **Physician supervision requirements**
- ◆ **Payment rate changes for drugs, biologicals, radiopharmaceuticals, and brachytherapy sources**
- ◆ **New benefit categories under MIPPA**



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Physician Supervision

- ◆ **Background and some reasons for the controversy**
 - **Supervision "assumed" in the hospital setting by providers as a result of language from the April 2000 OPPS final rule**
 - **CMS believed things were clear, but providers strongly disagreed, including the American Hospital Association**
 - **CMS issued a "restatement and clarification" in the 2009 OPPS final rule, but providers continued to find it insufficient and raised many questions during 2009**
 - **CMS indicated that it will not withdraw the longstanding physician supervision policies for hospital outpatient services, and recognized there was some confusion prior to January 1, 2009 (but not after)**

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Physician Supervision

- ◆ **Key items addressed in the 2010 OPPS final rule:**
 - Clarification of the level of supervision required
 - Practitioners who are qualified to provide direct supervision for outpatient therapeutic services
 - Requirements associated with where they can be located and what they need to be able to do
 - Descriptions of “immediately available”
 - Concerns related to compliance risks

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A Framework for Distilling the Physician Supervision Requirements

- ◆ **Who can provide “direct” supervision?**
- ◆ **What services? What must the physician or NPP be able to do?**
- ◆ **Where are the services being offered?**
- ◆ **When and How must the physician or NPP be able to respond or be available?**
- ◆ **Why? does CMS continue to emphasize this requirement?**

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Physician Supervision: Who?

♦ Who can provide supervision?

- As of January 1, 2010, CMS will allow ***physicians and non-physician practitioners (specifically physician assistants, nurse practitioners, clinical nurse specialists, clinical psychologist, certified nurse-midwives, and licensed clinical social workers)*** to ***directly*** supervise all hospital outpatient therapeutic services that they may perform themselves in accordance with their state law and scope of practice and hospital-granted privileges
- The person providing the direct supervision does not necessarily need to be of the same specialty as the procedure or service being performed

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Physician Supervision: Who?

♦ Hospitalists

- Hospitals may need to negotiate contracts/incentive payments to meet the physician supervision requirements
- Hospitals may need to define/refine the scope of work of some of its practitioners
- ♦ **Emergency department physicians**
- ♦ **How will you prove the "who"?**

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Physician Supervision: What?

- ♦ ***What "services"?***
 - Medicare Part B pays for ***hospital outpatient therapeutic services only*** when they are provided under the "direct" supervision of a physician and, starting in 2010, for therapeutic services provided under the direct supervision of certain non-physician practitioners as defined by CMS
 - Typical therapeutic services provided in hospital outpatient departments include:
 - IV therapy
 - Oncology
 - Wound care
 - Radiation therapy
 - Others, all departments providing outpatient therapeutic services

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Physician Supervision: What?

- ♦ ***What must the physician or NPP be able to do?***
 - The supervising physician or NPP must be prepared to step in and perform the service, not just respond to an emergency. This includes the ability to take over performance of a procedure and, as appropriate, change a procedure or the course of treatment being provided to a particular patient.

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Physician Supervision: Where?

- ◆ **Where are the services being offered?**
 - “In the hospital” or in on-campus provider-based departments, the supervising physician or NPP:
 - Can be located *anywhere* on the same campus of the hospital, as long as he or she is immediately available
 - Can be in non-hospital space
 - Does not have to be in the same department or same room
 - For services in off-campus provider-based departments, the supervising physician or NPP
 - Must be located in the department (no change)
 - CMS also states, *“We continue to believe it would be inappropriate to allow one physician or NPP to supervise all services being provided in all provider based departments at a particular off-campus outpatient location.”*

Note: CMS defines “in the hospital” as the main buildings under the ownership and control of the hospital, operated by the hospital, and billed under the hospital’s certification number.

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Physician Supervision: When & How?

- ◆ **When and How, must the physician or NPP be able to respond or be available?**
 - CMS indicates that the physician or NPP must be *immediately available to furnish direction and assistance* throughout the *performance of the procedure*
 - **Immediately available (e.g., When)**
 - “Without interval of time” was not finalized for 2010
 - CMS indicates that the supervisory physician or NPP could not be immediately available while, for example, performing another procedure or service that he or she could not interrupt.
 - *CMS stated: “It would be neither appropriate nor ‘immediate’ for the supervisory physician or non-physician practitioner to be so physically far away on the main campus from the location where hospital outpatient services are being furnished that he or she could not intervene right away.”*

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Physician Supervision: When & How?

- **Furnish direction and assistance (*How*):**
 - Not simply able to respond in an emergency
 - The physician or NPP must be able to step in and take over the procedure
 - Must have within their scope of practice and hospital granted privileges the ability to perform all services being supervised
- **Throughout the performance of the procedure (*How*):**
 - All services and procedures covered incident to
 - All covered components of those services, including packaged components (i.e. recovery)

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Physician Supervision: Why?

- ♦ **Why?**
 - To provide safe, effective, high-quality healthcare services to Medicare beneficiaries
 - If direct physician supervision is not provided, then Medicare has concerns about patient quality of care.
 - To assist in a procedure or service that is not going as planned or that has resulted in some adverse reaction, outcome, etc.
 - The supervising physician or NPP must be prepared to step in and perform the service, not just respond to an emergency. This includes the ability to take over the performance of the procedure and to change a procedure or course of treatment, if necessary.

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Physician Supervision: Discussion Items and Questions

- ◆ **Documentation**
- ◆ **Developing internal policies and procedures**
- ◆ **Addressing "911" vs. "411" calls**
- ◆ **Assessing compliance risk**
 - **2000 to 2008 – probably low**
 - **2009 – medium**
 - **2010 and beyond – high**
- ◆ **Open items**
- ◆ **Discussion**

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MIPPA Calls for Expanded Coverage in Two Specific Clinical Areas

- ◆ **Coverage of KDE services for Medicare beneficiaries diagnosed with stage IV chronic kidney disease (CKD) who, according to accepted clinical guidelines identified by the Secretary, will require dialysis or a kidney transplant, effective for services furnished on or after January 1, 2010.**
 - KDE services must be defined along with a clear specification of "qualified persons" who may furnish these services (refers to clinical persons and entities)
- ◆ **Coverage and payment for pulmonary and cardiac rehabilitation services provided to beneficiaries with chronic obstructive pulmonary disease and certain other conditions, beginning on January 1, 2010.**
 - The OPPS final rule provides for payment for services in a cardiac rehabilitation (CR) program, an intensive cardiac rehabilitation (ICR) program, or a pulmonary rehabilitation (PR) program furnished to hospital outpatients.

Tip: Review the physician fee schedule for a more detailed discussion

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Kidney Disease Patient Education Services

- ◆ Qualified persons = a physician, PA, NP, or clinical nurse specialist (CNS)
- ◆ Qualified providers = hospital, critical access hospital (CAH), skilled nursing facility (SNF), comprehensive outpatient rehabilitation facility (CORF), home health agency (HHA), or hospice located in a rural area, or a hospital that has been reclassified from urban to rural.
- ◆ Two new G-codes assigned with status indicator "A"
 - G0420: Educational services related to the care of chronic kidney disease; individual per session, per hour, face-to-face
 - G0421: Educational services related to the care of chronic kidney disease; group, per session; per hour, face-to-face

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Kidney Disease Patient Education Services

- ◆ A single payment will be made for each KDE session (1 hour long), limited to no more than six sessions
- ◆ May be provided individually or in group settings of 2 - 20 individuals, who need not all be Medicare beneficiaries
- ◆ Qualified persons must develop outcome assessments and each beneficiary must be assessed during one of the education sessions
- ◆ Separate payment will not be provided for both a physician's professional services and the associated facility services *if* a single session of KDE services is furnished in a rural hospital or CAH
- ◆ Payment will only be made to one qualified person for KDE services on the same day for the same beneficiary using rates published in the physician fee schedule

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Cardiac, Pulmonary, and Intensive Cardiac Rehabilitation Services – General

- ♦ Information is in *both* the Physician Fee Schedule and the OPPS/APC rule
- ♦ Supervision *must* occur by a doctor of medicine or osteopathy (non-physician practitioners cannot provide the supervision for CR, ICR, or PR)
- ♦ Patients in PR, CR, or ICR programs must receive the full complement of care defined under the benefit, including assessments and individualized treatments in accordance with their written treatment plan
- ♦ CR and ICR programs consist of exercise, cardiac risk factor modification, psychosocial assessment, outcomes assessment, and other services
- ♦ Services provided are *individualized* and set forth in *written treatment plans* that describe the patient's *diagnosis; the type, amount, frequency, and duration of items and services* furnished under the plan; and the *goals* set for the individual under the plan. These written plans must be *established, reviewed, and signed by a physician every 30 days.*

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Cardiac, Pulmonary, and Intensive Cardiac Rehabilitation Services – General

- ♦ Question raised about whether physical therapists can report services that might be a part of a PR, CR, or ICR program, separately:
 - Hospitals are expected to provide the full scope of the PR, CR, or ICR benefit, as comprehensive programs, to patients who qualify and be paid as hospital outpatient services under OPPS. CMS does not expect to see component services of PR, CR, and ICR programs unbundled and billed separately by different providers under other benefit categories
- ♦ Though uncommon, CMS does recognize some patients may receive care under a PR, CR, or ICR treatment plan and also physical therapy services under a separate physical therapy plan of care
 - But, hospitals can *never* bill both physical therapy and PR, CR, or ICR services for the same time period for the same patient (Ex: an hour session from 10:00-- 11:00 a.m. on a single date of service can only be billed in one way)
- ♦ CMS will monitor PR, CR, and ICR claims data along with claims for therapy services to check for inappropriate billing patterns

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Cardiac Rehabilitation and Intensive Cardiac Rehabilitation Services

- ♦ **Two physician roles exist in the CR and ICR programs:**
 - **Medical director:** physician who oversees/supervises the CR and ICR program at each site and who has expertise in the management of patients with cardiac pathophysiology. This person *must be involved substantially* in directing the progress of individuals in the program.
 - **Supervising physician:** physician who is immediately available and accessible for consultations and emergencies at all times. This physician must also have expertise in the management of individuals with cardiac pathophysiology.
 - Physician supervision must be provided by either program medical director or the supervising physician and **NOT** another CR or ICR staff member.
 - Medical directors and supervising physicians must possess : (1) Expertise in the management of individuals with cardiac pathophysiology. (2) Cardiopulmonary training in basic life support or advanced cardiac life support. (3) A license to practice medicine in the State the cardiac rehabilitation program is offered.

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Cardiac Rehabilitation Update

- ♦ **MIPPA requires comprehensive programs to include:**
 - Cardiac risk factor modification – education, counseling, and behavioral intervention (smoking cessation, nutritional education and meal planning, etc.)
 - Psychosocial assessment
 - Outcomes assessment – patient-centered outcomes must be measured no fewer times than at the beginning and end of the CR program
 - CR services be provided under written individualized treatment plans
 - Direct physician supervision is the standard
- ♦ **Patients with the following clinical conditions can participate:**
 - Documented diagnosis of an acute MI within the prior 12 months,
 - Coronary bypass surgery
 - Stable angina pectoris
 - Heart valve repair/replacement
 - PTCA or coronary stenting
 - Heart or heart/lung transplant

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Cardiac Rehabilitation Update

- ◆ **CR services are reported using CPT® codes 93797 & 93798 assigned to APC 0095 with a payment rate of \$38.36:**
 - **93797: Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)**
 - **93798: Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)**

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Cardiac Rehabilitation Update

- ◆ **CR is covered for up to 36 one-hour sessions (over 36 weeks), with a minimum of 1 session per week and a maximum of 2 sessions per day; Medicare contractors can approve up to 36 additional sessions over an additional period of time, for a total of 72 total sessions**
- ◆ **Each day that CR items and services are furnished to a patient, aerobic exercises along with other exercises must be included (i.e., a patient must exercise aerobically every day he or she attends a CR session)**

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Intensive Cardiac Rehabilitation Services

- ◆ **Beneficiaries eligible for ICR must have experienced the following:**
 - **an acute myocardial infarction within the preceding 12 months**
 - **coronary bypass surgery**
 - **current stable angina pectoris**
 - **a heart valve repair or replacement**
 - **a percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting**
 - **a heart or heart-lung transplant**

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Intensive Cardiac Rehabilitation Services

- ◆ **To qualify for Medicare coverage, an ICR program must demonstrate, through peer-reviewed published research, that it has accomplished one or more of the following:**
 - **Positively affected the progression of CAD**
 - **Reduced the need for coronary bypass surgery**
 - **Reduced the need for percutaneous coronary interventions**

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Intensive Cardiac Rehabilitation Services

- ♦ The ICR program must also demonstrate, through peer-reviewed published research, that it has accomplished a statistically significant reduction for patients in five or more specific measures (comparing individual levels before and after receipt of ICR services):
 - LDL, triglycerides, BMI, systolic blood pressure, diastolic blood pressure and need for cholesterol, blood pressure and diabetes meds
- ♦ All ICR programs must be approved through an NCD process. Once approved, an ICR program(s), or individual sites wishing to furnish ICR items and services via an approved ICR program, may enroll with their local Medicare contractor to become an ICR program supplier
- ♦ CMS released instructions for the NCD at:
http://www.cms.hhs.gov/MCD/viewnca.asp?nca_id=239&basket=nca:00418N:239:Intensive+Cardiac+Rehabilitation+%28ICR%29+Program+%2D+Pritikin+Program:Open:New:1

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Intensive Cardiac Rehabilitation Services

- ♦ Two new HCPCS codes to report ICR services
 - G0422: (Intensive cardiac rehabilitation; with or without continuous ECG monitoring, *with exercise, per hour, per session*)
 - G0423: (Intensive cardiac rehabilitation; with or without continuous ECG monitoring, *without exercise, per hour, per session*)
 - Both G-codes assigned to APC 0095 (same as cardiac rehab)
- ♦ MIPPA defines "an intensive cardiac rehabilitation program may be provided in a series of 72 one-hour sessions, up to 6 sessions per day, over a period of up to 18 weeks."
- ♦ More sessions of ICR can be provided compared to CR
 - Hospitals should report appropriate units, up to "6" if applicable, on a single date of service using the units of service field; six times the APC payment for APC 0095 will be made for 6 hours of ICR

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Pulmonary Rehabilitation Services

- ♦ MIPPA provides coverage for pulmonary rehabilitation furnished on or after 1/1/2010 for Medicare beneficiaries with a diagnosis of moderate severe COPD (Gold classification II, III, and IV).
- ♦ A PR program includes *all* of the following:
 - Physician prescribed exercise
 - Education or training (to the extent it's clearly related to the individual's needs)
 - Psychosocial assessment
 - Outcomes assessment
 - Other items/services as deemed appropriate under certain conditions
- ♦ Written individualized treatment plan for each patient is required and it must be reviewed and signed by the physician every 30 days. The plan must include the scope of services to be provided and goals set for the patient.

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Pulmonary Rehabilitation Services

- ♦ PR services must be billed using new HCPCS G-code code, ***G0424***
 - G0424 – Pulmonary rehabilitation, including exercise (includes monitoring) per hour, per session
 - APC 0102 (Level II Pulmonary Treatment) with a payment of \$50.46
 - Existing HCPCS codes G0237, G0238, and G0239 (for respiratory treatment services, CPT® codes for individual assessment services, or HCPCS codes for physical therapy or other services) *cannot be used*
- ♦ Up to 36, one-hour sessions allowed; the MAC can approve up to 36 additional sessions if medically necessary
- ♦ Maximum of two, one-hour sessions are allowed per day

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***2010 Final Rule Update for Payment
of Drugs, Biologicals,
Radiopharmaceuticals, and Blood
and Blood Products***



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***Drugs, Biologicals, and
Radiopharmaceuticals***

- ◆ **Packaged drugs, including contrast agents**
- ◆ **Separately payable drugs, including pass-through drugs**
- ◆ **Diagnostic and therapeutic radiopharmaceuticals**
- ◆ **Brachytherapy sources**

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Packaged Drugs

♦ Packaged drugs – several changes for 2010:

- CMS finalized an increase to its drug packaging threshold
 - 2009 – Drugs with a median cost < \$60 = packaged
 - 2010 – Drugs with a median cost < \$65 = packaged
- 5HT3 anti-emetics no longer will be exempt from the packaging threshold
- Some drugs that were separately payable in 2009 may not be in 2010, and vice versa
- Contrast agents continue to be packaged
- Diagnostic radiopharmaceuticals continue to be packaged

Tip: CMS reminds providers that they should report packaged services, including drugs, contrast etc.

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Elimination of Separate Payment for Most 5HT3 Anti-emetics

TABLE 34. FINAL CY 2010 STATUS INDICATORS FOR 5-HT3 ANTIEMETICS

CY 2010 HCPCS Code	CY 2010 Long Descriptor	CY 2010 SI
J1260	Injection, dolasetron mesylate, 10 mg	N
J1626	Injection, granisetron hydrochloride, 100 mcg	N
J2405	Injection, ondansetron hydrochloride, per 1 mg	N
J2469	Injection, palonosetron hcl, 25 mcg	K
Q0166	Granisetron HCL, 1 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 24-hour dosage regimen	N
Q0179	Ondansetron HCL 8 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen	N
Q0180	Dolasetron mesylate, 100 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 24-hour dosage regimen	N

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2009 Separately Payable Drugs Packaged in 2010

HCPCS Code	2009				2010				Impact		
	Short Descriptor	SI	APC	Payment Rate	Short Descriptor	CI	SI	APC	Payment Rate	\$ Chg in Pmt Rte	% Chg in Pmt Rte
C9355	Neuromatrix nerve cuff, cr	G	9355	\$215.88	Neuromatrix	CH	N		\$0.00	(\$215.88)	-100%
C9354	Veritas collagen matrix, c	G	9354	\$11.77	Veritas coll	CH	N		\$0.00	(\$11.77)	-100%
J1260	Dolasetron mesylate	K	0750	\$4.32	Dolasetron	CH	N		\$0.00	(\$4.32)	-100%
Q0180	Dolasetron mesylate oral	K	0763	57.3	Dolasetron	CH	N		0	(\$57.30)	-100%
90696	Dtap-ipv vacc 4-6 yr im	K	1219	\$39.77	Dtap-ipv vad	CH	N		\$0.00	(\$39.77)	-100%
J1455	Foscarnet sodium injectio	K	1189	\$9.86	Foscarnet s	CH	N		\$0.00	(\$9.86)	-100%
Q0166	Granisetron hcl 1 mg oral	K	0765	6.95	Granisetron	CH	N		0	(\$6.95)	-100%
J1626	Granisetron hcl injection	K	0764	\$1.97	Granisetron	CH	N		\$0.00	(\$1.97)	-100%
J3473	Hyaluronidase recombina	K	1228	\$0.58	Hyaluronida	CH	N		\$0.00	(\$0.58)	-100%
J1835	Itraconazole injection	K	9047	\$41.48	Itraconazole	CH	N		\$0.00	(\$41.48)	-100%
J7518	Mycophenolic acid	K	9219	\$2.92	Mycophend	CH	N		\$0.00	(\$2.92)	-100%
J8650	Nabilone oral	K	1230	\$16.64	Nabilone or	CH	N		\$0.00	(\$16.64)	-100%
Q0179	Ondansetron hcl 8 mg ora	K	0769	10.22	Ondansetron	CH	N		0	(\$10.22)	-100%
J2405	Ondansetron hcl injection	K	0768	\$0.24	Ondansetron	CH	N		\$0.00	(\$0.24)	-100%
J8510	Oral busulfan	K	7015	\$3.15	Oral busulf	CH	N		\$0.00	(\$3.15)	-100%
J3472	Ovine, 1000 USP units	K	1703	\$127.86	Ovine, 1000	CH	N		\$0.00	(\$127.86)	-100%
J9265	Paclitaxel injection	K	0863	\$8.94	Paclitaxel i	CH	N		\$0.00	(\$8.94)	-100%
J2515	Pentobarbital sodium inj	K	1223	\$11.73	Pentobarbit	CH	N		\$0.00	(\$11.73)	-100%
J9270	Plicamycin (mithramycin)	K	1231	\$92.03	Plicamycin	CH	N		\$0.00	(\$92.03)	-100%
J2805	Sincalide injection	K	1224	\$66.78	Sincalide in	CH	N		\$0.00	(\$66.78)	-100%
J3400	Triflupromazine hcl inj	K	1218	\$20.51	Trifluproma	CH	N		\$0.00	(\$20.51)	-100%
J3350	Urea injection	K	1227	\$12.05	Urea injecti	CH	N		\$0.00	(\$12.05)	-100%
J9390	Vinorelbine tartrate inj	K	0855	\$11.95	Vinorelbine	CH	N		\$0.00	(\$11.95)	-100%

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2009 Packaged Drugs with Separate APC Payment in 2010

HCPCS Cod	2009				2010				Impact		
	Short Descriptor	SI	AP	Payment Rate	Short Descript	CI	SI	AP	Payment Rate	\$ Chg in Pmt Rte	% Chg in Pmt Rte
90476	Adenovirus vaccine, type	N		\$0.00	Adenovirus	CH	K	1254	\$72.17	\$72.17	100%
J7197	Antithrombin iii injection	N		\$0.00	Antithrombi	CH	K	1263	\$2.28	\$2.28	100%
Q2004	Bladder calculi irrig sol	N		0	Bladder cal	CH	K	1293	29.28	\$29.28	100%
J0945	Brompheniramine maleate	N		\$0.00	Bromphenir	CH	K	1256	\$0.75	\$0.75	100%
90725	Cholera vaccine, injectabl	N		\$0.00	Cholera vac	CH	K	1271	\$0.16	\$0.16	100%
J7515	Cyclosporine oral 25 mg	N		\$0.00	Cyclosporin	CH	K	1294	\$0.82	\$0.82	100%
J1324	Enfuvirtide injection	N		\$0.00	Enfuvirtide i	CH	K	1257	\$0.47	\$0.47	100%
J1817	Insulin for insulin pump us	N		\$0.00	Insulin for ir	CH	K	1277	\$3.34	\$3.34	100%
J9212	Interferon alfacon-1 inj	N		\$0.00	Interferon al	CH	K	1266	\$6.75	\$6.75	100%
J2321	Nandrolone decanoate 10	N		\$0.00	Nandrolone	CH	K	1260	\$7.00	\$7.00	100%
J2322	Nandrolone decanoate 20	N		\$0.00	Nandrolone	CH	K	1286	\$14.74	\$14.74	100%
J2320	Nandrolone decanoate 50	N		\$0.00	Nandrolone	CH	K	1285	\$7.00	\$7.00	100%
90680	Rotavirus vacc 3 dose, or	N		\$0.00	Rotavirus va	CH	K	1255	\$72.37	\$72.37	100%

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Separately Payable Drugs

- ♦ Separately payable drugs have a median cost > \$65
- ♦ 2009 APC payment based on the average sales price (ASP) + 4%, which is intended to cover acquisition cost and pharmacy handling/overhead
- ♦ The problem...
 - CMS's current rate-setting methodology for separately payable drugs (which relies on provider claims data for separately payable drugs and manufacturer submitted [ASP]) fails to appropriately account for separately payable drug acquisition and pharmacy handling/overhead costs
 - Many analyses have shown that the costs of pharmacy handling/overhead are at least 25%, and could be as much as 33%, of the department's costs but are likely being "compressed" for separately payable drugs

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Separately Payable Drugs

- ♦ CMS' usual methodology for creating separately payable drug APC rates for 2010, would have resulted in ASP MINUS 3% (ASP-3%)
- ♦ Paying less acquisition cost, which the ASP is a proxy for, is clearly a problem that is due in part to charge compression
 - Differential drug mark-up practices resulting in "charge compression" have led CMS to underestimate pharmacy handling/overhead costs associated with high-cost drugs, and over-estimate these costs for low-cost, packaged drugs which are distributed throughout the APC payment system

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Separately Payable Drugs

- ♦ The solution...
 - Re-allocate money from packaged drugs to separately payable drugs in recognition of “charge compression” prior to computing the ASP plus percentage...or just find a way to get to the magic number of “ASP+4%” which the agency seems stuck on
 - Upon conclusion of several analyses and the inclusion of provider comments, CMS:
 - Reallocated \$150 million in costs associated with packaged drugs with HCPCS codes and average sales price data from non-drug APCs to separately payable drugs
 - Reallocated an additional \$50 million in costs associated with packaged drugs and no HCPCS codes from non-drug APCs to separately payable drug payment rates, based on information provided by commenters!

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Separately Payable Drugs

- ♦ CMS admitted that the \$50 million reallocation from packaged drugs with NO HCPCS was “conservative”
 - Pharmacy overhead costs associated with drugs and biologicals reported without HCPCS codes were not considered for reallocation in the proposed rule. In response to commenters’, CMS decided to consider a small percentage of this cost for redistribution to separately payable drugs for 2010.
- ♦ What more can CMS do?
 - Continue to study the issue, especially the split between packaged drugs reported with HCPCS codes and those reported WITHOUT HCPCS codes and re-allocate more money from packaged drugs without HCPCS codes to the separately payable drug pool.
 - Provide guidance on how providers could/should report their drugs... which it has done in the 2010 OPSS Final Rule!

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Separately Payable Drugs

- ♦ **Reminder from CMS:** Hospitals have a variety of ways to bill for packaged drugs and biologicals, but **NOT** all of these will result in CMS being able to use the drug charge data for setting drug reimbursement rates:
 - Packaged drugs reported with a HCPCS code (rev code 636 vs. 250 may pose an issue) generate no separate payment but the charge information may be used by CMS for future rate setting – **Best practice**
 - Providers may incorporate the charge for drugs/biologicals in the charge for the procedure. In these cases, CMS cannot identify the cost associated with the drug because its rolled into the procedure and not reported with a pharmacy rev code. These drug costs are not available for CMS to use in future rate setting – **Not good**
 - Providers often report packaged drugs using pharmacy revenue code 0250, and no HCPCS code but these costs are not really usable by CMS – **Not good, yet a lot of the 2008 packaged drug charges appear in this category. CMS was only comfortable reallocating \$50 million from here.**

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Separately Payable Drugs

- ♦ **What can hospitals do?**
 - CMS says: ***"If hospitals truly desire significantly greater OPPS payment accuracy for separately payable drugs and biologicals, it is clear that hospitals will need to assume some burden in submitting more accurate data to us."***
 - CMS says: ***"CMS' longstanding policy is to refrain from instructing hospitals on charging practices for services under most revenue codes. While we do not require hospitals to use revenue code 0636 (Pharmacy-Extension of 025x; Drugs Requiring Detailed coding [a]) when billing for drugs and biologicals that have HCPCS codes, whether they are separately payable or packaged, we believe that a practice of billing all drugs and biologicals with HCPCS codes under revenue code 0636 would be consistent with NUBC billing guidelines and would provide us with the most complete and detailed information for rate-setting."***

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Separately Payable Drugs

- CMS says: "We note that we make packaging determinations for drugs annually based on cost information reported under HCPCS codes, so the OPPS rate-setting is best served when hospitals report charges for all items and services that have HCPCS codes under those HCPCS codes, whether or not payment for the items and services is packaged or not."
- CMS says: "More complete data from hospitals on which drugs were provided for a specific episode would help improve payment accuracy for separately payable drugs in the future, and we encourage hospitals to change their reporting practices if they are not already reporting HCPCS codes for all drugs furnished, if specific codes are available."
 - **Bottom Line:** Hospitals should report HCPCS codes for ALL drugs that have a HCPCS code, regardless of whether they are packaged or separately payable, and it seems best to do this using revenue code 636

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Separately Payable Drugs in 2009 That Appear "Deleted" for 2010

- ♦ HCPCS codes with status indicator "D"
- ♦ Look to see if a different/replacement code has been created
 - Update your CDM, especially your dosage conversion/calculator

HCPCS Cod	Short Descriptor	2009				2010				Impact	
		AP	Payment Rate	AP	Payment Rate	\$ Chg in Pmt Rte	% Chg in Pmt Rte				
C9251	Inj, C1 esterase inhibitor	G	925	\$41.34	CH	D		\$0.00	(\$41.34)	-100%	
C9249	Inj, certolizumab pegol	G	924	\$3.80	CH	D		\$0.00	(\$3.80)	-100%	
C9246	Inj, gadoxetate disodium	G	924	\$13.50	CH	D		\$0.00	(\$13.50)	-100%	
C9247	Inj, iobenguane, I-123, dx	G	924	\$2,329.83	CH	D		\$0.00	(\$2,329.83)	-100%	
C9252	Injection, plerixafor	G	925	\$268.51	CH	D		\$0.00	(\$268.51)	-100%	
C9245	Injection, romiplostim	G	924	\$43.75	CH	D		\$0.00	(\$43.75)	-100%	
C9253	Injection, temozolomide	G	925	\$4.90	CH	D		\$0.00	(\$4.90)	-100%	
J0835	Inj cosyntropin per 0.25 MG	K	083	\$91.84	CH	D		\$0.00	(\$91.84)	-100%	
Q2024	Bevacizumab injection	K	128	1.41	CH	D		0	(\$1.41)	-100%	
J9170	Docetaxel injection	K	082	\$339.02	CH	D		\$0.00	(\$339.02)	-100%	
J0550	Penicillin g benzathine inj	K	121	\$34.79	CH	D		\$0.00	(\$34.79)	-100%	
J1565	RSV-ivg	K	090	\$15.87	CH	D		\$0.00	(\$15.87)	-100%	
J7322	Synvisc inj per dose	K	087	\$239.03	CH	D		\$0.00	(\$239.03)	-100%	
Q2023	Xyntha, inj	K	126	1.06	CH	D		0	(\$1.06)	-100%	

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Three Billing Examples for Docetaxel

Current Code Left in CDM and Reported											
CPT/ HCPCS	2009 Units	Description	2009			2010			APC Payment Impact	2009 Total Hospital Payment	2010 Total Hospital Payment
			SI	APC	Payment rate	SI	APC	Payment rate			
J9170	1,420	Docetaxel injection, 20 mg	K	0823	\$ 339.02	D		\$ -	\$(339.02)	\$481,408.40	\$0.00
New Code Added to CDM with No Correction to Units Conversion Calculator											
CPT/ HCPCS	2009 Units	Description	2009			2010			Dollar Impact	2009 Total Hospital Payment	2010 Total Hospital Payment
			SI	APC	Payment rate	SI	APC	Payment rate			
J9170	1,420	Docetaxel injection, 20 mg	K	0823	\$ 339.02	D		\$ -	\$(339.02)	\$481,408.40	
J9171	1,420	Docetaxel injection, 1 mg			\$ -	K	0823	\$ 16.95	\$ 16.95		\$24,069.00
New Code and Appropriate Units Conversion Created in the CDM/Pharmacy Calculator											
CPT/ HCPCS	2009 Units	Description	2009			2010			Dollar Impact	2009 Total Hospital Payment	2010 Total Hospital Payment
			SI	APC	Payment rate	SI	APC	Payment rate			
J9170	1,420	Docetaxel injection, 20 mg	K	0823	\$ 339.02	D		\$ -	\$(339.02)	\$481,408.40	
J9171	28,400	Docetaxel injection, 1 mg			\$ -	K	0823	\$ 16.95	\$ 16.95		\$481,380.00

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Pass-Through Drugs

- ◆ **Pass-Through drugs – Preamble tables 30 and 31**
 - CMS did not finalize its proposal to change the date criteria associated with pass-through drug eligibility
 - Pass-through drugs – newest drugs with HCPCS codes (SI G)
 - 6 expire – see table below – SI changes for 4 from G to K
 - 37 remain with payment based on ASP+6% - pay attention to HCPCS changes from 2009 to 2010 – Update CDM accordingly

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Pass-Through Drugs

		2009				2010				Impact	
HCPCS Code	Short Descriptor	Q	AP	Payment Rate	Short Descriptor	CI	Q	AP	Payment Rate	\$ Chg in Pmt Rte	% Chg in Pmt Rte
J1300	Eculizumab injection	G	9236	\$180.98	Eculizumab	CH	K	9236	\$177.57	(\$3.41)	-2%
J9261	Nelarabine injection	G	0825	\$103.23	Nelarabine	CH	K	0825	\$101.28	(\$1.95)	-2%
J3488	Reclast injection	G	0951	\$222.79	Reclast inj	CH	K	0951	\$218.59	(\$4.20)	-2%
J9330	Temsirolimus injection	G	1168	\$48.85	Temsirolim	CH	K	1168	\$47.93	(\$0.92)	-2%
C9355	Neuromatrix nerve cuff, cr	G	9355	\$215.88	Neuromatrix	CH	N		\$0.00	(\$215.88)	-100%
C9354	Veritas collagen matrix, c	G	9354	\$11.77	Veritas coll	CH	N		\$0.00	(\$11.77)	-100%

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Pass-Through Drugs and Codes in Effect for 2010

CY 2009 HCPCS Code	CY 2010 HCPCS Code	CY 2010 Long Descriptor	Final CY 2010 SI	Final CY 2010 APC
C9245	J2796	Injection, romiplostim, 10 micrograms	G	9245
C9246	A9581	Injection, gadoxetate disodium, 1 ml	G	9246
C9247	A9582	Iodine I-123 iobenguane, diagnostic, per study dose, up to 15 millicuries	G	9247
	A9583	Injection, gadofosveset trisodium, 1 ml	G	1299
C9248	C9248	Injection, clevipiden butyrate, 1 mg	G	9248
C9249	J0718	Injection, certolizumab pegol, 1 mg	G	9249
C9250	C9250	Human plasma fibrin sealant, vapor-heated, solvent-detergent (Artiss), 2ml	G	9250
C9251	J0598	Injection, C1 esterase inhibitor (human), 10 units	G	9251
C9252	J2562	Injection, plerixafor, 1 mg	G	9252
C9253	J9328	Injection, temozolomide, 1 mg	G	9253
	C9255	Injection, paliperidone palmitate, 1 mg	G	1300
	C9256	Injection, dexamethasone intravitreal implant, 0.1 mg	G	9256
C9356	C9356	Tendon, porous matrix of cross-linked collagen and glycosaminoglycan matrix (TenoGlide Tendon Protector Sheet), per square centimeter	G	9356
C9358	C9358	Dermal substitute, native, non-denatured collagen, fetal bovine origin (SurgiMend Collagen Matrix), per 0.5 square centimeters	G	9358
C9359	C9359	Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Putty, Integra OS Osteoconductive Scaffold Putty), per 0.5 cc	G	9359
C9360	C9360	Dermal substitute, native, non-denatured collagen, neonatal bovine origin (SurgiMend Collagen Matrix), per 0.5 square centimeters	G	9360

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Pass-Through Drugs and Codes in Effect for 2010

CY 2009 HCPCS Code	CY 2010 HCPCS Code	CY 2010 Long Descriptor	Final CY 2010 SI	Final CY 2010 APC
C9361	C9361	Collagen matrix nerve wrap (NeuroMend Collagen Nerve Wrap), per 0.5 centimeter length	G	9361
C9362	C9362	Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Strip), per 0.5 cc	G	9362
C9363	C9363	Skin substitute, Integra Meshed Bilayer Wound Matrix, per square centimeter	G	9363
C9364	C9364	Porcine implant, Permacol, per square centimeter	G	9364
J0641	J0641	Injection, levoleucovorin calcium, 0.5 mg	G	1236
J1267	J1267	Injection, doripenem, 10 mg	G	9241
J1453	J1453	Injection, fosaprepitant, 1 mg	G	9242
J1459	J1459	Injection, immune globulin (privigen), intravenous, non-lyophilized (e.g. liquid), 500 mg	G	1214
J1571	J1571	Injection, hepatitis b immune globulin (hepagam b), intramuscular, 0.5 ml	G	946
J1573	J1573	Injection, hepatitis B immune globulin (Hepagam B), intravenous, 0.5ml	G	1138
J1680	J1680	Injection, human fibrinogen concentrate, 100 mg	G	1290
J1953	J1953	Injection, levetiracetam, 10 mg	G	9238
J2785	J2785	Injection, regadenoson, 0.1 mg	G	9244
J8705	J8705	Topotecan, oral, 0.25 mg	G	1238
J9033	J9033	Injection, bendamustine hcl, 1 mg	G	9243
J9155	J9155	Injection, degarelix, 1 mg	G	1296
J9207	J9207	Injection, ixabepilone, 1 mg	G	9240
J9225	J9225	Histrelin implant (vantas), 50 mg	G	1711
J9226	J9226	Histrelin implant (supprelin la), 50 mg	G	1142
	Q0138	Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg (non-esrd use)	G	1297
Q4114	Q4114	Dermal substitute, granulated cross-linked collagen and glycosaminoglycan matrix (Flowable Wound Matrix), 1 cc	G	1251

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Diagnostic Radiopharmaceuticals (RPs)

- **Diagnostic RPs and contrast agents are considered ancillary and supportive to diagnostic tests and therapeutic procedures in which they are used and remain packaged for 2010**
 - **Reminder – CMS edits for the presence of a radiopharmaceutical on every claim submitted with a nuclear medicine procedure**
 - **CMS has not specifically defined which radiopharmaceutical(s) must be billed with the nuclear medicine procedures.**
 - **Note: inpatient diagnostic RP administration followed by an outpatient Nuc Med service to be billed and paid under new HCPCS code C9898**
 - **CMS has told providers that, in cases where the radiopharmaceutical is administered several days before the nuclear medicine service is furnished, the hospital will need to hold the claim until after the service is furnished so the radiopharmaceutical is on the same the bill as the nuclear medicine procedure**

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Therapeutic Radiopharmaceuticals

- ◆ **2009 cost-based reimbursement expires for 2010**
- ◆ **New payment rate methodology will be in effect – *ASP + 4%***
 - **Based on manufacturer submitted average sales price if available or on CMS' usual rate-setting method relying on claims data**
- ◆ **Status indicator changes from "H" to "K"**
- ◆ **Conduct a financial impact analysis for these services**

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Therapeutic Radiopharmaceuticals

	2009				2010				Impact
HCPCS Cod	Short Descriptor	AP	Payment Rate	C	AP	Payment Rate	Payment Rate	\$ Chg in Pmt Rte	
A9517	I131 iodide cap, rx	H	106	\$0.00	CH	K	1064	\$16.51	\$16.51
A9530	I131 iodide sol, rx	H	115	\$0.00	CH	K	1150	\$11.02	\$11.02
A9545	I131 tositumomab, rx	H	164	\$0.00	CH	K	1645	\$9,929.05	\$9,929.05
A9564	P32 chromic phosphate	H	167	\$0.00	CH	K	1676	\$113.44	\$113.44
A9563	P32 Na phosphate	H	167	\$0.00	CH	K	1675	\$196.49	\$196.49
A9600	Sr89 strontium	H	070	\$0.00	CH	K	0701	\$647.67	\$647.67
A9543	Y90 ibritumomab, rx	H	164	\$0.00	CH	K	1643	\$15,532.15	\$15,532.15
A9605	Sm 153 lexidronm	H	070	\$0.00	CH	D		\$0.00	\$0.00

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Brachytherapy

- ◆ 2009 cost-based reimbursement expires for 2010
- ◆ Payment rates based on CMS' usual rate-setting method relying on claims data
- ◆ Status indicator remains the same (U)
- ◆ Subject to outlier payments and the 7.1% adjustment payment if applicable
- ◆ Conduct a financial impact analysis for these services

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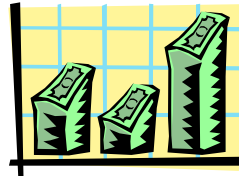
Brachytherapy

HCPCS Cod	Short Descriptor	2009			2010			Impact \$ Chg in Pmt Rte
		U	AP	Payment Rate	U	AP	Payment Rate	
C2636	Brachy linear, non-str,P-103	U	263	\$0.00	U	2636	\$19.37	\$19.37
C1716	Brachytx, non-str, Gold-198	U	171	\$0.00	U	1716	\$42.85	\$42.85
C2634	Brachytx, non-str, HA, I-125	U	263	\$0.00	U	2634	\$59.80	\$59.80
C2635	Brachytx, non-str, HA, P-103	U	263	\$0.00	U	2635	\$28.59	\$28.59
C1717	Brachytx, non-str,HDR Ir-192	U	171	\$0.00	U	1717	\$231.38	\$231.38
C2616	Brachytx, non-str, Yttrium-90	U	261	\$0.00	U	2616	\$15,779.35	\$15,779.35
C2699	Brachytx, non-stranded, NOS	U	269	\$0.00	U	2699	\$28.59	\$28.59
C2643	Brachytx, non-stranded,C-131	U	264	\$0.00	U	2643	\$66.09	\$66.09
C2639	Brachytx, non-stranded,I-125	U	263	\$0.00	U	2639	\$36.18	\$36.18
C2641	Brachytx, non-stranded,P-103	U	264	\$0.00	U	2641	\$57.12	\$57.12
C1719	Brachytx, NS, Non-HDRIr-192	U	171	\$0.00	U	1719	\$64.02	\$64.02
C2642	Brachytx, stranded, C-131	U	264	\$0.00	U	2642	\$109.84	\$109.84
C2638	Brachytx, stranded, I-125	U	263	\$0.00	U	2638	\$42.48	\$42.48
C2698	Brachytx, stranded, NOS	U	269	\$0.00	U	2698	\$42.48	\$42.48
C2640	Brachytx, stranded, P-103	U	264	\$0.00	U	2640	\$60.36	\$60.36
A9527	Iodine I-125 sodium iodide	U	263	\$0.00	U	2632	\$37.92	\$37.92

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General Financial Updates for 2010

- ◆ **Conversion factor update**
- ◆ **Hold harmless**
- ◆ **Outliers**
- ◆ **Hospital quality data reporting related payment impact**
- ◆ **APC reclassification**
- ◆ **Packaging and composite APCs**
- ◆ **Estimating financial impact**



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Financial Impact Overview of the 2010 OPPS Final Rule: The Basics

- ◆ **Financial Update**
 - **Two national conversion factors continue for 2010:**
 - Conversion factor for hospitals that **MEET** the quality reporting requirements increases to **\$67.406 from \$66.059 in 2009**
 - Conversion factor for hospitals that do **NOT** meet the quality reporting requirements increases to **\$66.086 from \$64.784 in 2009**
 - **Maximum beneficiary co-payment is 40%, but most APCs are at the minimum of 20%**
 - **25% co-payment to screening flexible sigmoidoscopies and screening colonoscopies**

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Financial Impact Overview of the 2010 OPSS Final Rule: The Basics

◆ **Hold harmless**

- Financial protection mechanism against OPSS “losses”
- Children’s hospitals & Cancer Centers continue to have permanent hold harmless status
- Currently, rural hospitals, including small community hospitals (SCHs) and Essential Access Community Hospitals (EACHs) with 100 beds or less, receive 85% of the difference between the OPSS payment and the previous cost-based system, but this protection EXPIRES for 2010
- CMS will continue to protect Rural SCHs, including EACHs by continuing to increase payment rates by 7.1% for all services/ procedures paid under OPSS, excluding separately payable drugs and biologicals, pass-through devices, and items paid at cost

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Financial Impact Overview of the 2010 OPSS Final Rule: The Basics

2009 Outlier Payment Policy

- Line item level for all separately payable APCs except separately payable drugs, biologicals, radiopharmaceuticals, and brachytherapy sources
- Outlier pool = 1% of total OPSS payments; and .12% of outlier pool for CMHC for partial hospitalizations
- Two threshold model
 - multiplier threshold = 1.75
 - the fixed dollar threshold = \$1800
- CMS pays 50% of the difference when both thresholds are met
- CMHCs subject to a different formula with a multiplier threshold of 3.4 and no fixed dollar threshold

2010 Outlier Payment Policy

- **No change** *except CMS clarifies that items paid at cost will not be eligible for outlier consideration*
- **Outlier pool** = 1% of total OPSS payments; with .03% of the pool allocated for CMHCs for partial hospitalizations
- **Two threshold model**
 - multiplier – no change = 1.75
 - fixed dollar threshold increased to \$2175
- **No change**
- **No change**
- **Other:** Cost report changes underway including cost report reconciliation process

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Hospital Quality Data Initiative

- ♦ No new quality measures finalized for CY 2010
- ♦ 11 measures must be reported to receive full OPPS update
- ♦ Some hospitals are exempt from reporting...*for now*
- ♦ Hospitals that fail to meet reporting requirements in 2009 will see a 2% payment reduction in 2010; those that fail to meet reporting requirements in 2010 will face payment reductions in 2011
 - CMS has separate conversion factors to implement reduced payments.
 - Beneficiary and secondary payer payments, along with outlier payments, will be determined by using the reduced APC payment rates
- ♦ Administrative and data collection requirements remain quite the same
- ♦ Validation to begin in 2010 – *review this information internally!*
- ♦ More measures expected in the future, along with use of concepts such as present on admission and healthcare-associated conditions (HACs)

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Reclassification of Codes, APCs, and Status Indicators

- ♦ **Reclassification – “2X Rule Violation”**
 - Annual review of items/services within an APC group to determine, with respect to comparability of the use of resources, if the median of the highest cost item/service within a APC group is 2 times greater than the median of the lowest cost item/service within the same group
 - New, deleted, and modified HCPCS/CPT® codes, APCs, and status indicators
 - APC-specific policies discussed, but there appears to be less code movement than in previous years
 - **Bottom Line:** *CPT® reassignment and APC reconfiguration results in payment rate changes that could be higher or lower than current payment rates (i.e., new technology APCs)*

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Reminder about Status Indicators

- ◆ **Status indicators (SI) are assigned to each CPT®/HCPCS code and tell us something about whether/how the service is payable:**
 - Services paid under OPPS (SI = G, K, N, P, Q, R, S, T, U, V, & X)
 - Services paid under another payment system (SI = A, C, F, L, and Y)
 - Services not recognized under OPPS but may be recognized by other institutional providers or there may be a better code (SI = B)
 - Services not payable by Medicare (SI = M, E)
 - Services/CPT® codes deleted (SI = D)
- ◆ **Status indicator "H" deleted; items assigned to status K**
- ◆ **No new indicators added for 2010, but some definitions revised**
- ◆ **CMS has changed its rate-setting method for certain status indicators**
 - ***Reminder:*** status indicator changes can lead to APC payment changes and therefore financial impact

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Reminder on Comment Indicators (CI)

- ◆ **CH: 2010 Final Rule calls attention to codes with status indicators and/or APC assignments changes for CY 2010**
 - Useful to facilitate the review of all changes being finalized from year to the next
- ◆ **NI: New code, interim APC assignment; Comments accepted until December 29, 2009**
 - 329 codes designated as "NI"
 - Important to utilize for CPT®/HCPCS Updates
 - Codes with substantially revised CPT® definitions also assigned indicator NI
 - Other items, outside those flagged "NI", are open for comment

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APC-Specific Policy Changes: New Technology APCs

- ◆ Remember that CMS typically keeps new services in a new technology APC for 2-3 years or until data are available for analysis, then the service is assigned to a clinical APC
- ◆ For 2010, CMS finalized its proposal to move 0182T for high dose rate brachytherapy from a new technology APC to a clinical, resulting in a large payment reduction

CPT/ HCPCS	Description	SI	APC	Payment rate	SI	APC	Payment rate	Payment Impact
		2009			2010			
0182T	Hdr elect brachytherapy	S	1519	\$ 1,750.00	S	0313	\$ 777.55	
				\$ 1,750.00			\$ 777.55	\$ (972.45)

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Payment Impact Examples Due to APC Recalibration/Reconfiguration

CPT/ HCPCS	Description	SI	APC	Payment rate	SI	APC	Payment rate	Dollar Impact
		2009			2010			
G0251	Linear acc based stero radio	S	0065	\$ 952.38	S	0065	\$ 962.61	\$ 10.23
G0340	Robot lin-radsurg fractx 2-5	S	0066	\$ 2,579.82	S	0066	\$ 2,488.08	\$ (91.74)
G0173	Linear acc stereo radsur com	S	0067	\$ 3,803.23	S	0067	\$ 3,571.78	\$ (231.45)
77371	Srs, multisource	S	0127	\$ 7,641.69	S	0127	\$ 7,344.27	\$ (297.42)
G0339	Robot lin-radsurg com, first	S	0067	\$ 3,803.23	S	0067	\$ 3,571.78	\$ (231.45)

Intracavitary and Interstitial Brachytherapy

CPT/ HCPCS	Description	SI	APC	Payment rate	SI	APC	Payment rate	Dollar Impact
		2009			2010			
77777	Apply interstit radiat inter	S	0312	\$ 430.66	S	0312	\$ 302.29	\$ (128.37)
77776	Apply interstit radiat simpl	S	0312	\$ 430.66	S	0312	\$ 302.29	\$ (128.37)
77763	Apply intrcav radiat compl	S	0312	\$ 430.66	S	0312	\$ 302.29	\$ (128.37)
77762	Apply intrcav radiat interm	S	0312	\$ 430.66	S	0312	\$ 302.29	\$ (128.37)
77761	Apply intrcav radiat simple	S	0312	\$ 430.66	S	0312	\$ 302.29	\$ (128.37)
77778	Apply interstit radiat compl	Q3	0651	\$ 866.17	Q3	0651	\$ 893.50	\$ 27.33

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Examples of Payment Impact Due to APC Recalibration/Reconfiguration

Gastrointestinal Services							
CPT/HCPCS	Description	SI	APC	Payment rate	SI	APC	Payment rate
				2009			
				2010			
43760	Change gastrostomy tube	T	0121	\$ 303.59	T	0676	\$ 161.46
47371	Laparo ablate liver cryosurg	T	0131	\$ 3,060.10	T	0174	\$ 7,409.52
49652	Lap vent/abd hernia repair	T	0130	\$ 2,502.89	T	0132	\$ 4,917.82
49653	Lap vent/abd hern proc comp	T	0130	\$ 2,502.89	T	0132	\$ 4,917.82
49654	Lap inc hernia repair	T	0130	\$ 2,502.89	T	0132	\$ 4,917.82
49655	Lap inc hern repair comp	T	0130	\$ 2,502.89	T	0132	\$ 4,917.82
49656	Lap inc hernia repair recur	T	0130	\$ 2,502.89	T	0132	\$ 4,917.82
49657	Lap inc hern recur comp	T	0130	\$ 2,502.89	T	0132	\$ 4,917.82

Radiology							
CPT/HCPCS	Description	SI	APC	Payment rate	SI	APC	Payment rate
				2009			
				2010			
76098	X-ray exam, breast specimen	X	0317	\$ 337.19	Q2	0317	\$ 377.55

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Examples of Payment Impact Due to APC Recalibration/Reconfiguration

Orthopedic Services							
CPT/HCPCS	Description	SI	APC	Payment rate	SI	APC	Payment rate
				2009			
				2010			
29888	Knee arthroscopy/surgery	T	0042	\$ 3,251.11	T	0052	\$ 5,975.68
29889	Knee arthroscopy/surgery	T	0042	\$ 3,251.11	T	0052	\$ 5,975.68
29892	Ankle arthroscopy/surgery	T	0042	\$ 3,251.11	T	0052	\$ 5,975.68
27496	Decompression of thigh/knee	T	0049	\$ 1,438.83	T	0050	\$ 2,141.60
24400	Revision of humerus	T	0050	\$ 1,973.95	T	0051	\$ 3,139.68
25350	Revision of radius	T	0052	\$ 5,720.43	T	0051	\$ 3,139.68

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Packaged Items/Services: Review of What Medicare Says

- ♦ Packaging entails associating the cost of ancillary, supportive, and interrelated services and supplies with a distinct service or composite service.
- ♦ *CMS believes hospitals will continue to charge for packaged services, individually or as part of the charge for the independent service, because hospitals must charge all payers the same amount for services. Because some other payers pay a percentage of charges, to fail to charge for the packaged service would result in immediately reduced payment from sources other than Medicare and, over time, could also lead to a reduction in payment under the OPPS.*
- ♦ *Packaged items and services are covered and paid under the OPPS, even though they do not generate separate payment. Therefore, hospitals cannot issue ABNs to patients for packaged services.*

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No Changes to the Types of Services Being Packaged

- ♦ *Categories of packaged items, services, supplies:*
 - (1) use of an operating, treatment, or procedure room;
 - (2) use of a recovery room;
 - (3) observation services;
 - (4) anesthesia;
 - (5) medical/surgical supplies;
 - (6) pharmaceuticals (other than those that are deemed separately payable);
 - (7) incidental services such as venipuncture; and
 - (8) guidance services, image processing services, intraoperative services, imaging supervision and interpretation services, diagnostic radiopharmaceuticals, and contrast media (all added in CY 2008).

Reminder: there are two kinds of packaged services and they have different status indicators.

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Understanding the Difference Between Two Types of Packaged Services

- ♦ **Unconditionally packaged status "N"**
 - Services that are **ALWAYS packaged** – no separate payment ever
- ♦ **Conditionally packaged status "Q"**
 - Services that are **OFTEN packaged**, but can be separately payable in certain circumstances
 - Status indicator "Q" applies to three types of packaged services:
 - Q1 ("STVX" packaged codes)
 - Q2 ("T" packaged codes)
 - Q3 (codes that may be paid through a composite APC)
- ♦ **Reminder - there are 3 ways to report packaged services:**
 - Report the revenue code and a dollar charge with no HCPCS code
 - Build the packaged charges into the procedure/service charge *(note this carries cost reporting implications)*
 - Report the HCPCS/CPT® code, revenue code, and a dollar charge – *best option*

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Packaging vs. Composite APCs: Understanding the Similarities and Differences

- | Packaging | Composite APCs |
|--|---|
| <ul style="list-style-type: none"> ♦ Status indicator and/or the presence of other services provided on the same date drives separate payment ♦ Creates efficiency incentives for providers to furnish services and manage their resources with maximum flexibility ♦ Encourages hospitals to use least expensive item/supply that meets patient needs, rather than routinely providing an expensive item. ♦ Encourages hospitals to negotiate carefully with manufacturers and suppliers ♦ Encourages hospitals to establish protocols that ensure necessary services are furnished, while scrutinizing the services ordered to maximize efficient use resources | <ul style="list-style-type: none"> ♦ Combination of services on the same date of service drives separate APC or composite APC assignment ♦ Encourages hospitals to provide only what the patient needs, rather than routinely providing more ♦ Composite APCs provide a single payment for two or more major procedures commonly performed together, in order to promote efficiency by increasing the size of the payment bundle. ♦ CMS expects Composite APCs to encourage efficiency and to "allow hospitals maximum flexibility to manage their resources" |

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Review of Composite APCs

- ♦ CMS first introduced composite APCs in 2008
- ♦ Composites provide a single payment for specific combinations of services that would otherwise be separately payable if not provided together.
- ♦ ***No new composites for 2010; current composites continue:***
 - APC 8000: Cardiac Electrophysiologic Evaluation & Ablation
 - APC 8001: Low Dose Rate (LDR) Prostate Brachytherapy
 - APC 0034: Mental Health
 - APC 8002: Level I Extended Assessment and Management
 - APC 8003: Level II Extended Assessment and Management
 - APC 8004: Ultrasound
 - APC 8005: CT and CTA without contrast
 - APC 8006: CT and CTA with contrast
 - APC 8007: MRI and MRA without contrast
 - APC 8008: MRI and MRA with contrast

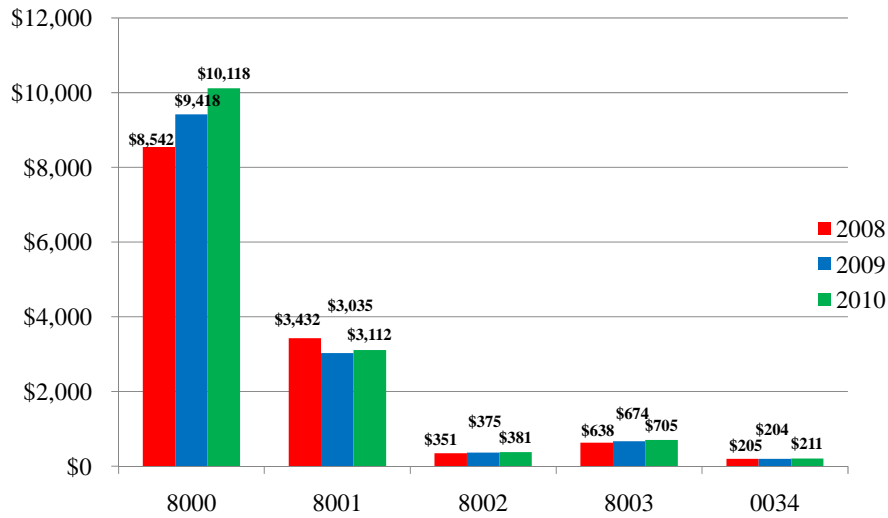
73

Review of Payment Policies for Multiple Imaging Composite APCs: 8004, 8005, 8006, 8007, and 8008

- ♦ One composite APC payment will be made when more than one HCPCS code from the ***same imaging family*** is provided on the ***same date of service***.
- ♦ If a procedure ***without contrast*** is performed during the same session (***same date of service***) as at least one other procedure ***with contrast*** in the same imaging modality, the hospital will receive payment for the "***with contrast***" composite.
- ♦ Imaging procedures performed from different imaging families will be paid according to standard OPPS methodology rather than the composite APC
- ♦ No change in how these HCPCS codes should be reported
- ♦ Multiple imaging Composite APCs are assigned status indicator "S", so no multiple APC payment reductions will occur if multiple composites are generated or if a composite occurs on the same day date of service as other significant procedures

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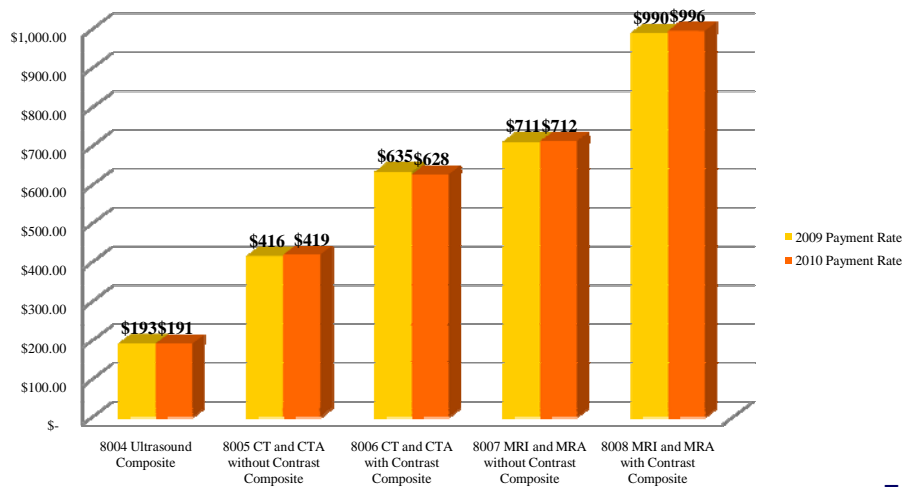
APC Composite Payment Comparison



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Additional APC Composite Payment Comparisons

Imaging Composite APC Payment Comparison (2009 vs. 2010 Rates)



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General and Facility Specific Financial Impact



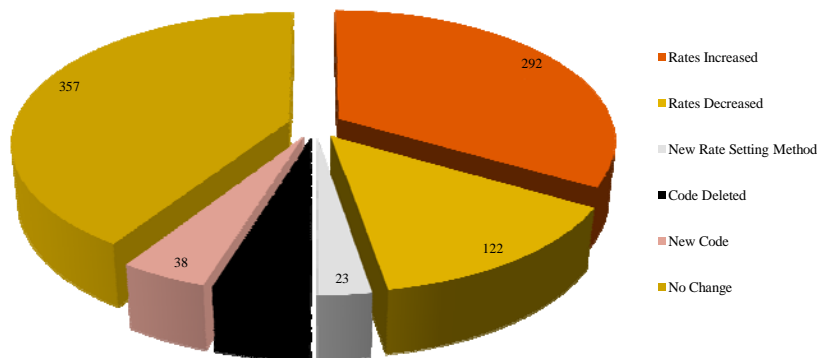
- ◆ Review CPT® codes flagged with comment indicator "CH" in Addendum B of the 2010 OPSS final rule and compare these payment rates to 2009 payment rates
- ◆ 30,000 foot view vs. 20,000 vs. 10,000 vs. facility-specific
 - Different views yield different information
 - Review top 25 CPT® codes by volume
 - Review top 25 CPT® codes by total charges
 - Review proposed new and deleted codes and APC assignments
 - Review codes by department/service line of interest

Remember, payment rates will increase or decrease based on CMS' recalibration of the overall system and, while OPSS is budget-neutral, it may not be for your organization. Facility-specific impact is fundamentally dependent on your mix of services, coding, charging, and billing practices!

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30,000 Foot View: APC Payment Rate Changes Finalized for OPSS 2010

APC Code Volumes - 2009 to 2010



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10,000 Foot View: Top 10 CPT® Codes with the Largest Payment Decrease for 2010

HCPCS Cod	Short Descriptor	2009			2010			Impact	
		AP	Payment Rate		AP	Payment Rate	\$ Chg in Pmt Rte	% Chg in Pmt Rte	
90665	Lyme disease vaccine, im	K	121	\$72.67	K	1216	\$0.93	(\$71.74)	-99%
P9050	Granulocytes, pheresis unit	R	950	1669.99	R	9506	44.92	(\$1,625.07)	-97%
37799	Vascular surgery procedure	T	010	1038.87	CH X	0624	41.33	(\$997.54)	-96%
93299	Icm/ilr remote tech serv	S	020	\$754.41	CH S	0689	\$38.29	(\$716.12)	-95%
35226	Repair blood vessel lesion	T	009	1917.98	CH T	0020	552.92	(\$1,365.06)	-71%
95149	Antigen therapy services	S	043	\$128.62	CH S	0437	\$37.44	(\$91.18)	-71%
P9020	Platelet rich plasma unit	R	095	394.95	R	0958	136.79	(\$258.16)	-65%
78610	Brain flow imaging only	S	040	548.71	CH S	0403	196.7	(\$352.01)	-64%
93278	ECG/signal-averaged	X	034	\$42.69	CH X	0035	\$15.64	(\$27.05)	-63%
75898	Follow-up angiography	Q1	026	199.51	CH Q1	0261	75.23	(\$124.28)	-62%
11760	Repair of nail bed	T	013	227.34	CH T	0133	91.28	(\$136.06)	-60%
13122	Repair wound/lesion add-on	T	013	227.34	CH T	0133	91.28	(\$136.06)	-60%
96111	Developmental test, extend	Q3	038	\$161.38	CH Q3	0373	\$65.77	(\$95.61)	-59%
51710	Change of bladder tube	T	042	1030.48	CH T	0121	429.66	(\$600.82)	-58%
94370	Breath airway closing volume	X	036	\$37.17	CH X	0035	\$15.64	(\$21.53)	-58%

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10,000 Foot View: Top 15 CPT® Codes with the Largest Payment Increase for 2010

HCPCS Cod	Short Descriptor	2009			2010			Impact	
		AP	Payment Rate		AP	Payment Rate	\$ Chg in Pmt Rte	% Chg in Pmt Rte	
P9043	Plasma protein fract,5%,50ml	R	095	15.62	R	0956	65.75	\$50.13	321%
67101	Repair detached retina	T	023	384.97	CH T	0237	1396.28	\$1,011.31	263%
96567	Photodynamic tx, skin	T	001	\$54.70	CH T	0016	\$188.62	\$133.92	245%
74475	X-ray control, cath insert	Q2	031	337.19	CH Q2	0161	1148.22	\$811.03	241%
74480	X-ray control, cath insert	Q2	031	337.19	CH Q2	0161	1148.22	\$811.03	241%
74485	X-ray guide, GU dilation	Q2	031	337.19	CH Q2	0161	1148.22	\$811.03	241%
94680	Exhaled air analysis, o2	X	036	\$55.00	CH X	0369	\$176.79	\$121.79	221%
78601	Brain image w/flow < 4 views	S	040	186.52	CH S	0402	578.65	\$392.13	210%
P9011	Blood split unit	R	096	31.12	R	0967	87.39	\$56.27	181%
47371	Laparo ablate liver cryosurg	T	013	3060.1	CH T	0174	7409.52	\$4,349.42	142%
30802	Cauterization, inner nose	T	025	497.62	CH T	0253	1158.57	\$660.95	133%
88162	Cytopath smear, other source	X	043	\$16.50	CH X	0343	\$35.73	\$19.23	117%
95921	Autonomic nerv function test	S	021	\$39.60	CH S	0218	\$80.65	\$41.05	104%
99407	Behav chng smoking > 10 mir	X	003	\$11.42	X	0031	\$23.24	\$11.82	104%
99406	Behav chng smoking 3-10 mir	X	003	\$11.42	X	0031	\$23.24	\$11.82	104%

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Round up of Operational and Other Items for OPPS 2010

- ◆ **Drug administration (injections and infusion)**
- ◆ **Evaluation and management codes**
- ◆ **Observation services**
- ◆ **Inpatient only list**
- ◆ **Device related procedure APCs**
- ◆ **Partial Hospitalization**



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2010 Drug Administration



- ◆ **Operational impact (coding, billing impact)**
 - **No CPT® code changes for 2010, but there is *some new text in the 2010 CPT® book***
 - **Hospitals should continue following the CPT® rules and hierarchy**
 - **Confusion still remains around certain concepts and billing of certain services**
 - **Audits have begun related to time documentation and the use of modifier - 59 with injection codes**

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2010 Update for Drug Administration

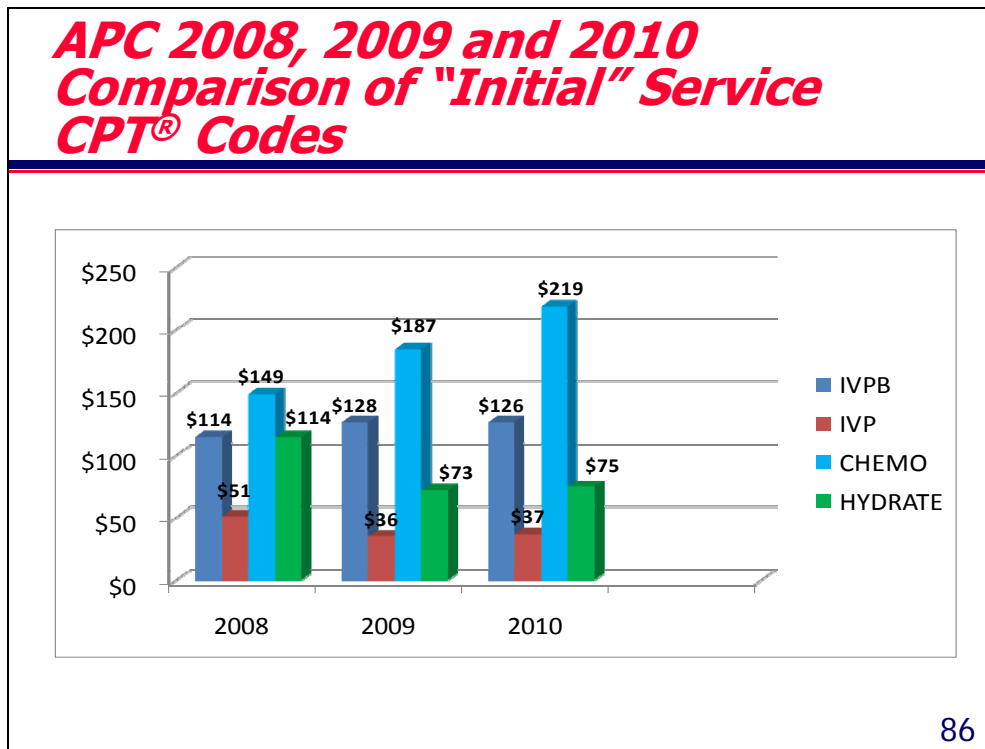
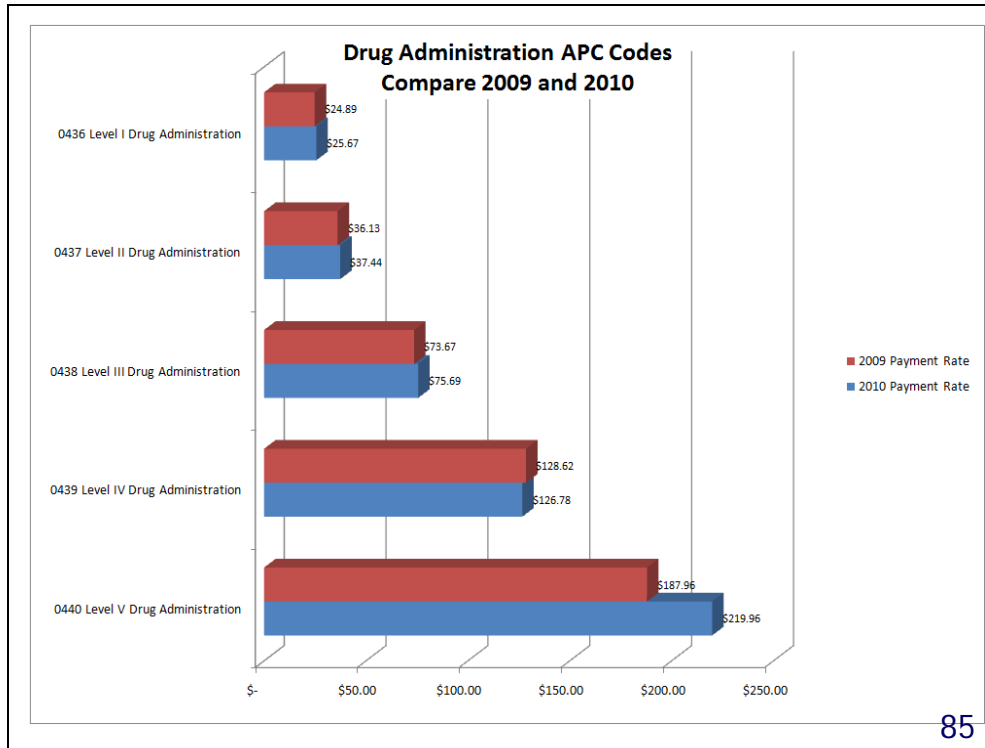
- ♦ **New text** in the 2010 CPT® book is located above "Hydration"
 - *"When these codes are reported by the facility, the following instructions apply. The initial code should be selected using a hierarchy whereby chemotherapy services are primary to therapeutic, prophylactic, and diagnostic services which are primary to hydration services. Infusions are primary to pushes, which are primary to injections."*
 - *"This hierarchy is to be followed by facilities and supersedes parenthetical instructions for add-on codes that suggest an add-on of a higher hierarchical position may be reported in conjunction with a base code of a lower position."*
 - *"The hierarchy would not permit reporting 96376 with 96360 as 96376 is a higher order code. IV push is primary to hydration."*

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2010 Drug Administration

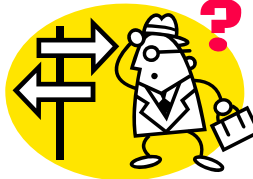
- ♦ **Financial impact**
 - 5 drug administration APCs continue
 - CMS backed off some the proposed CPT® to APC reconfigurations
 - Still no separate payment for multiple IV push injections of the same substance/drug – (96376) or concurrent infusions (96368)
 - Huge payment increase for chemotherapy infusion, initial
 - Review payment increases/decreases by CPT® code
 - Don't forget about Medically Unlikely Edits (MUEs) and National Correct Coding Initiative (NCCI) edits

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Ongoing Drug Administration Issues

- ◆ **Time documentation**
 - What do you consider a best practice?
 - Who's auditing what?
- ◆ **Modifier -59**
 - Monitor the OIG website
- ◆ **Official guidance is often still confusing**
 - Example: the February 2009 CPT® Assistant Q/As...
 - Varying FI/MAC guidance
- ◆ **Reporting drug administration services for patients receiving observation services**
- ◆ **Reporting drug administration services on overnight patients**



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Hospital Coding and Payment for E/M Visits

- ◆ **Still no national E/M coding guidelines**
- ◆ **CMS is still seeing a stable distribution of billed E/M visit code data**
- ◆ **CMS will continue to work on national guidelines and encourages comments and submission of successful models**
- ◆ **CMS continues to expect hospitals to use internally developed guidelines based on the 11 principles listed in the CY 2008 final rule (72 FR 66085)**
- ◆ **CMS does not expect individual hospitals to necessarily experience a normal distribution of visit levels**

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Hospital Coding and Payment for E/M Visits

- ◆ **Clinic Visits – no changes to codes or APC groups**
 - New patient: 99201-99205: 5 levels/5 distinct APC groups
 - Established patient: 99211 – 99215: 5 levels/4 distinct APC groups
 - *Definition for new vs. established remains in effect and pertains to whether or not the patient was registered as an inpatient or outpatient of the hospital within the past 3 years*
- ◆ **Type A and B ED Visits – no changes to codes, but one new group created**
 - HCPCS codes G0380-G0384 – 5 levels/5 distinct APC groups
 - *New Level V Type B ED APC created*

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Review of Other Useful Information from CMS on Hospital Coding and Payment for E/M Visits

- ◆ Hospitals can have multiple sets of internal guidelines for different clinics, but they must all measure resource use in a relative manner to each other.
- ◆ CMS believes it will be reasonable for hospitals to adjust their guidelines annually, if necessary.
- ◆ CMS encourages FIs/MACs to use a hospital's guidelines in an audit
- ◆ CMS reminds providers: "*Billing a visit code in addition to another service merely because the patient interacted with hospital staff or spent time in a room for that service is inappropriate...*"
- ◆ Remember that your levels should not include services for which you are able to receive APC separate payment
- ◆ CMS does not expect providers to change/adapt their guidelines just to meet the separately payable Composite observation APC criteria

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Hospital Coding and Payment for E/M Visits

HCPCS Code	2009				2010				Impact		
	Short Descriptor	SI	APC	Payment Rate	Short Descriptor	CI	SI	APC	Payment Rate	\$ Chg in Pmt Rte	% Chg in Pmt Rte
99201	Office/outpatient visit, new	V	0604	54.68	Office/outpatient visit, new	V	0604	57.92	57.92	3.24	5.9%
99202	Office/outpatient visit, new	V	0605	68.96	Office/outpatient visit, new	V	0605	69.68	69.68	0.72	1.0%
99203	Office/outpatient visit, new	V	0606	89.74	Office/outpatient visit, new	V	0606	89.12	89.12	-0.62	-0.7%
99204	Office/outpatient visit, new	V	0607	113.57	Office/outpatient visit, new	V	0607	113.44	113.44	-0.13	-0.1%
99205	Office/outpatient visit, new	Q3	0608	161.69	Office/outpatient visit, new	Q3	0608	167.52	167.52	5.83	3.6%
99211	Office/outpatient visit, est	V	0604	54.68	Office/outpatient visit, est	V	0604	57.92	57.92	3.24	5.9%
99212	Office/outpatient visit, est	V	0605	68.96	Office/outpatient visit, est	V	0605	69.68	69.68	0.72	1.0%
99213	Office/outpatient visit, est	V	0605	68.96	Office/outpatient visit, est	V	0605	69.68	69.68	0.72	1.0%
99214	Office/outpatient visit, est	V	0606	89.74	Office/outpatient visit, est	V	0606	89.12	89.12	-0.62	-0.7%
99215	Office/outpatient visit, est	Q3	0607	113.57	Office/outpatient visit, est	Q3	0607	113.44	113.44	-0.13	-0.1%
99281	Emergency dept visit	V	0609	52.66	Emergency dept visit	V	0609	53.16	53.16	0.5	0.9%
99282	Emergency dept visit	V	0613	86.14	Emergency dept visit	V	0613	87.85	87.85	1.71	2.0%
99283	Emergency dept visit	V	0614	136.7	Emergency dept visit	V	0614	140.18	140.18	3.48	2.5%
99284	Emergency dept visit	Q3	0615	217.91	Emergency dept visit	Q3	0615	223.17	223.17	5.26	2.4%
99285	Emergency dept visit	Q3	0616	323.9	Emergency dept visit	Q3	0616	329.73	329.73	5.83	1.8%
99291	Critical care, first hour	Q3	0617	485.39	Critical care, first hour	Q3	0617	495.38	495.38	9.99	2.1%
G0380	Lev 1 hosp type B ED visit	V	0626	45.18	Lev 1 hosp type B ED visit	V	0626	45.81	45.81	0.63	1.4%
G0381	Lev 2 hosp type B ED visit	V	0627	61.45	Lev 2 hosp type B ED visit	V	0627	62.21	62.21	0.76	1.2%
G0382	Lev 3 hosp type B ED visit	V	0628	88.64	Lev 3 hosp type B ED visit	V	0628	98.22	98.22	9.58	10.8%
G0383	Lev 4 hosp type B ED visit	V	0629	159.16	Lev 4 hosp type B ED visit	V	0629	141.83	141.83	-17.33	-10.9%
G0384	Lev 5 hosp type B ED visit	Q3	0616	323.9	Lev 5 hosp type B ED visit	CH	Q3	0630	232.32	-91.58	-28.3%

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Review: CMS' Thoughts on Observation

- ♦ **CMS said: "We define observation care as an active treatment to determine if a patient's condition is going to require that he or she be admitted as an inpatient or if the condition resolves itself and the patient is discharged. The currently required diagnostic tests reflect that an active assessment of the patient was being undertaken, and we believe they are generally medically necessary to determine whether a beneficiary will benefit from being admitted to observation care and aid in determining the appropriate disposition of the patient following observation care."**
- ♦ **In the 2010 OPPS Final Rule, CMS clarifies that Observation is a service and not a patient status.**

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Observation Services Composite APCs: Review and Update for 2010

- ♦ **APCs 8002 (Level I Extended Assessment and Management Composite)**
 - Describes an encounter for care provided to a patient that requires a high level (99205 OR 99215) clinic visit OR direct admission to observation (G0379) in conjunction with observation services of substantial duration (G0378 must be reported with \geq 8 hours)
 - ***No changes for 2010***
- ♦ **APC 8003 (Level II Extended Assessment and Management Composite)**
 - Describes an encounter for care provided to a patient that requires a high level (99284 OR 99285) ED visit OR critical care (99291) in conjunction with observation services of substantial duration (G0378 must be reported with \geq 8 hours)
 - ***No changes for 2010***

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Observation Services and Condition Code 44 Clarification for 2010 from the Final Rule

- ♦ Several commenters requested clarification of the reporting of observation services in relation to maternity care paid under another payer's policies and in relation to changes in patient status from inpatient to outpatient using Condition Code 44. One commenter pointed out that references to "observation status" versus "inpatient admission" are potentially confusing for beneficiaries and physicians.
 - Response: *"Each of these comments/questions is outside of the scope of the proposals in the CY 2010 OPSS/ASC proposed rule. However, we will consider the possibility of addressing these concerns through other available mechanisms, as appropriate. We note that we have continued to emphasize that observation care is a hospital outpatient service, ordered by a physician and reported with a HCPCS code, like any other outpatient service. It is not a patient status for Medicare purposes."*

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Inpatient Only List Status Indicator C



- ◆ **List continues on in 2010 – Long live the list**
 - Services are only **paid** when they are provided in an inpatient setting due to the nature of the procedure and need for postoperative recovery time/monitoring
 - CMS reviews the list annually and removes services from the list, if warranted, and places the codes in an appropriate APC group
 - **For 2010, CMS removed more procedures from the list than originally proposed, as a result of commenters' suggestions**
 - 8 procedures removed from the list and placed in a clinical APC
 - Complete list of inpatient-only procedures is in **Addendum E: remember, only SHORT descriptors are included in the Addenda.**
 - Be sure to review **LONG** descriptions by using the CPT® manual; provide information to your physicians and/or other appropriate hospital staff 95

TABLE 56.—PROCEDURES REMOVED FROM THE INPATIENT LIST AND THEIR

CY 2010 HCPCS Code	CY 2010 Long Descriptor	Final CY 2010 APC Assignment	Final CY 2010 Status Indicator
21256	Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (includes obtaining autografts) (eg, microphthalmia)	0256	T
27179	Open treatment of slipped femoral epiphysis; osteoplasty of femoral neck (Heyman type procedure)	0052	T
28805	Amputation, foot; transmetatarsal	0055	T
37215	Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection	0229	T
44950	Appendectomy	0153	T
44955	Appendectomy; when done for indicated purpose at time of other major procedure (not as separate procedure) (List separately in addition to code for primary procedure)	0153	T
51060	Transvesical ureterolithotomy	0163	T
63076	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophyctomy; cervical, each additional interspace (List separately in addition to code for primary procedure)	0208	T

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Pass-Through Devices and Device Related Procedure APCs

- ◆ No device categories eligible for pass-through payment in 2010
- ◆ No device categories proposed to lose pass-through status in 2010
- ◆ CMS will continue with its policy for reducing APC payments in cases where a device is received at no-charge/full-credit or the device is replaced with a partial credit from the manufacturer
 - Remember, this involves reporting the FB and FC modifiers
 - Beneficiary co-payment will be based on the reduced amount
 - Providers should appropriately reduce the price of devices received with partial credit

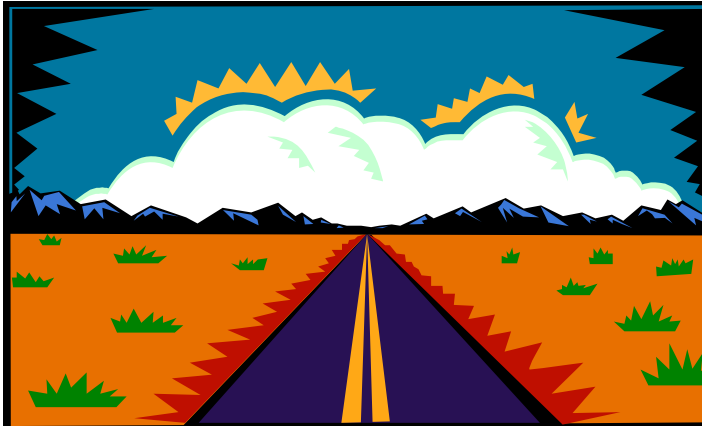
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Partial Hospitalization 2010

- ◆ The two-tiered payment approach that began in 2009 with two separate APC payments based on the number of partial hospitalization services rendered (three services vs. four or more) will continue in 2010
- ◆ Remember: "*Partial hospitalization is provided in lieu of inpatient care, therefore it is expected to be a highly structured and clinically intensive program, usually lasting most of the day.*"
- ◆ Only 2010 change was in the payment calculation:
 - Payment rates for APCs 0172 and 0173 set using ONLY hospital claims data instead of both hospital claims data and community mental health centers claims data
 - The result is better than it would have been had both sets of data been used, but the payment rate for APC 172 is 7% lower than the 2009 payment, while APC 173 sees a 4% increase

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Wrap-Up and Final Q/A



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What Should You Do With the Final Rule?

- ◆ **Download the rule (CMS -1414-FC) including the preamble tables and addenda**
 - Download the rule along with *preamble tables and addenda*
<http://www.cms.hhs.gov/HospitalOutpatientPPS/HORD/itemdetail.asp?filterType=none&filterByDID=99&sortByDID=3&sortOrder=descending&itemID=CMS1230047&intNumPerPage=10>
 - Federal Register version (more reader friendly and fewer pages) release date November 20, 2009
http://www.access.gpo.gov/su_docs/fedreg/frcont09.html
- ◆ **Look for additional coding and billing instructions from CMS**
 - January 2010 OPPS Update
 - January 2010 OCE Update
- ◆ **Review the new and deleted codes in your 2010 CPT® book**

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Final Thoughts/General Next Steps and Open Question and Answer Session

- ◆ Identify who needs to be involved in shoring up your compliance with the latest physician supervision information
- ◆ Review the key changes for 2010 with your revenue cycle team and map out your game plan
- ◆ Update your CDM, charge tickets, etc. and test internal systems and processes
- ◆ Monitor impact of the changes
- ◆ Prepare a financial impact analysis, especially for departments likely to face the largest financial or operational impact
- ◆ Remember that teamwork continues to be the key!

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Resource/Reference List

- ◆ **CMS. Hospital Outpatient Regulations and Notices.**
<http://www.cms.hhs.gov/HospitalOutpatientPPS/HORD/itemdetail.asp?filterType=none&filterByDID=99&sortByDID=3&sortOrder=descending&itemID=CMS1230047&intNumPerPage=10>
- ◆ **2009 Federal Register Online via GPO Access.**
http://www.access.gpo.gov/su_docs/fedreg/frcont09.html
- ◆ **CMS. NCA for Intensive Cardiac Rehabilitation (ICR) Program - Pritikin Program (CAG-00418N)**
http://www.cms.hhs.gov/MCD/viewnca.asp?from=basket&nca_id=239&viewAMA=N&basket=nca%3A00418N%3A239%3AIntensive+Cardiac+Rehabilitation+%28ICR%29+Program+%2D+Pritikin+Program%3AOpen%3ANew%3A2

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Thank You!

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December 15, 2009**

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Facts of Life in CPT®
January 12, 2010**

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CE Certificate Instructions	

Appendix

Resource/Reference List

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http://www.access.gpo.gov/su_docs/fedreg/frcont09.html

http://www.cms.hhs.gov/MCD/viewnca.asp?from=basket&nca_id=239&viewAMA=N&basket=nca%3A00418N%3A239%3AIntensive+Cardiac+Rehabilitation+%28ICR%29+Program+%2D+Pritikin+Program%3AOpen%3ANew%3A2



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