AHIMA
Distance Education

CY09 OPPS Update

Audio Seminar/Webinar

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Practical Tools for Seminar Learning

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The faculty has reported no vested interests or disclosures regarding this presentation.

Faculty

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Tanai S. Nelson is a remote coding consultant with United Audit System, Inc. (UASI) in Cincinnati, OH. Ms. Nelson has over five years of experience coding in the acute care setting, and ten years of experience coding and billing for physician professional services. She also serves as an AHIMA Communities of Practice facilitator, and sits on the Coding Community Council.

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Karen Scott is the owner of Karen Scott Seminars and Consulting, through which she teaches seminars on coding, reimbursement, medical terminology, and management. She has been an educator for many years, and has two AHIMA publications: Coding and Reimbursement for Hospital Inpatient Services and Medical Coding for the Non-Coder: Understanding Coding and Reimbursement in Today's Healthcare Society.

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Objective

- Update participants on the Medicare OPPS Changes effective on January 1, 2009.

1

Major Changes

- Updates Affecting OPPS Payments
- APC Group Policies
- Payment for Devices
- Changes for Drugs, Biologicals, and Radiopharmaceuticals
- Transitional Pass-Through Spending
- Payment for Brachytherapy Sources

2

Major Changes

- Payment for Drug Administration
- Hospital Outpatient Visits
- Partial Hospitalization Services
- Inpatient Only Procedures
- Status and Comment Indicators
- Hospital Outpatient Quality Data
- Healthcare – Associated Conditions

3

Updates Affecting OPPS Payments

- 424 HCPCS codes on the bypass list
- Packaged payment for IVIG
  - G0332 will be deleted 01/01/2009
- Packaged payment for EBUS and ultrasound guidance services

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APC Group Changes

- New HCPCS codes G0398, G0399 and G0400 assigned to APC 0213
  - Home sleep test (HST)
- 14 APC exceptions to the 2 times rule
- C9725 moved from APC 1507 to 0148
- C9726 moved from APC 1508 to 0028
- C9727 moved from APC 1510 to 0252

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APC Group Changes

- APC 0043 deleted
  - HCPCS codes reassigned to new APCs 0129, 0138 and 0139
- CPT® code 61793 deleted
  - 61796, 61797, 61798, 61799, 61800, 63620 and 63621 added
    - Assigned SI "B", Comment Indicator "NI"
    - HCPCS G-codes for SRS are recognized under OPPS

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APC Group Changes

- CPT® codes 97605 and 97606 moved to APC 0013

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APC Changes

- Code 64553 moved to APC 0040 from 0225
  - Changed to Percutaneous Implantation of Neurostimulator Electrode
- Recalculating APC 0225 to cost for 64573

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Echocardiology

- Reassigned 93307 to APC 0697
- Assigned new code 93306 to 0269
- Reassigned 76825 and 76826 fetal echos to APC 0269

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Nuclear Medicine

- Packaging payment for all diagnostic radiopharmaceuticals into payment for associated nuclear medicine procedure

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Notes/Comments/Questions

-CA Modifier When Pt. Expires

- Procedure on Inpt list performed on outpt
- Pt dies before being admitted
- Puts procedure into APC 0375
- Median cost $5,545
- No changes to policy

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Payment for Devices

- APCs 0425 (Level II Arthroplasty or Implantation with Prosthesis) and 0648 (Level IV Breast Surgery) and their associated devices added to the list of APCs to which the no cost/full credit and partial credit device adjustment policy applies

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Payment for Drug Administration

- Five-level APC structure for drug administration services implemented
  - DELETED - APC 0441 (Level VI Drug Administration)
- CY 2008 CPT® codes for drug administration services have been renumbered for CY 2009
- Payment for CPT® code 90768 is packaged

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Changes for Drugs, Biologicals, and Radiopharmaceuticals

- Expired pass-through status for 15 drugs and biologicals
- 24 drugs and biologicals with pass-through status in CY 2009

NOTE: If a drug or biological has been granted pass-through status becomes covered under the Part B drug CAP, payment will be provided at the Part B drug CAP rate.

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Packaged Payments

- Packaged Payments refer to a single reimbursement rendered for multiple services provided.

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Packaged Payments

- Conditionally Packaged Payment
  - Services believed to be *"typically integral"* to the performance of a primary service with which they are usually billed.
- Unconditionally Packaged Payment
  - Services believed are *"always integral"* to the performance of a primary service with which they are billed.

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Composite APCs

- Composite APCs were developed in CY 2008.
- Composite APCs provide a single payment for groups of services that are typically performed together during a single clinical encounter and that result in the provision of a complete service.

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Composite APCs

- Composite APCs create incentives for providers to furnish services in the most efficient way.
- Composite APCs enables hospitals to manage their resources with maximum flexibility by monitoring and adjusting the volume and efficiency of services.

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Composite APC 0034

- APC 0034 (Mental Health Services Composite)
  - ONLY paid if the sum of the individual payment rates for the specified mental health services provided on one date of service exceeds the APC 0034 payment rate which is the same as APC 0173.
  - The new SI "Q3" will be assigned to those HCPCS codes that describe the specified mental health services to which APC 0034 applies.

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NEW!
Multiple Imaging Composite APCs

- The 11 MPFS imaging families were collapsed into 3 OPPS imaging families according to their modality
  - (1) Ultrasound
  - (1) CT and CTA
  - (1) MRI and MRA

  (NOTE: There will be HCPCS code that overlap between the bypass list and the OPPS imaging families)
- The 3 modalities were expanded into five composite APCs.
- One composite APC payment will be made each time a hospital bills more than one procedure in one OPPS imaging family.

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NEW! Multiple Imaging Composite APCs

- **APC 8004 (Ultrasound Composite)**
- **APC 8005 (CT and CTA without Contrast Composite)**
- **APC 8006 (CT and CTA with Contrast Composite)**
- **APC 8007 (MRI and MRA without Contrast Composite)**
- **APC 8008 (MRI and MRA with Contrast Composite)**

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Composite APC 8000

- **APC 8000 (Cardiac Electrophysiologic Evaluation and Ablation Composite)**
  - **Consist of at least one specified electrophysiologic evaluation service and one electrophysiologic ablation service provided on the same date of service.**
  - **The new SI "Q3" will be assigned to HCPCS codes for this group that may be paid through a composite APC.**

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Composite APC 8000

Groups of Electrophysiologic Evaluation and Ablation Procedures

Codes Used in Combination	HCPCS Code	2009 APC	2009 SI
Group A			
Electrophysiologic Evaluation	93619	0085	Q3
Electrophysiologic Evaluation	93620	0085	Q3
Group B			
Ablate heart	93650	0085	Q3
Ablate heart	93651	0086	Q3
Ablate heart	93652	0086	Q3

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Composite APC 8001

- **APC 8001 (Low Dose Rate (LDR) Prostate Brachytherapy Composite)**
  - **The composite methodology implemented in CY 2008 will be continued in CY 2009.**
  - **The new SI "Q3" will be assigned to HCPCS codes (i.e., CPT® codes 55875 and 77778) that may be paid through a composite APC.**
  - **When the services represented by CPT® codes 55875 and 77778 are furnished in a single hospital encounter, the facility will receive a single payment under APC 8001.**
  - **When the services are billed individually, the facility will receive separate payment for individual services.**

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Composite APC 8002

- **APC 8002 (Level I Extended Assessment and Management Composite)**
  - **High level (Level 5) clinic visit or direct admission to observation with observation services of substantial duration.**

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Composite APC 8003

- **APC 8003 (Level II Extended Assessment and Management Composite)**
  - **High level (Level 4 or 5) emergency department visit or critical care service in conjunction with observation services of substantial duration.**
  - **NEW! HCPCS code G0384 added to the eligibility criteria.**
    - **HCPCS code G0384 is reassigned from APC 0608 to APC 0616**

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New and Established Patient

- CMS continues to believe it is appropriate to include a time limit when determining whether a patient is "new" or "established" from the hospital's perspective due to the expectation that care of a patient who was not treated at the hospital for several years prior to a visit could require significantly greater resources than care for a patient who was recently treated at the hospital.

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Clinic Visits

- CY 2009 OPPS Definition NEW!
  - The meanings of "new" and "established" would pertain to whether or not the patient was registered as an inpatient or outpatient of the hospital within the past 3 years.

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Clinic Visits

- **CY 2009 OPPS Definition NEW!**
  - **Hospitals would NOT need to determine the specific clinic where the patient was previously treated.**
  - **Hospitals would NOT need to determine when the medical record was initially created.**

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Clinic Visits

- **Established Patient**
  - **A patient who has been registered as an inpatient or outpatient of the hospital within the 3 years prior to the visit would be considered an "established" patient for that visit.**

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Clinic Visits

- New Patient
  - A patient who has NOT been registered as an inpatient or outpatient of the hospital within the 3 years prior to the visit would be considered a "new" patient for that visit.

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Polling Question #1

If the patient were registered as an outpatient in a hospital's off-campus provider-based clinic two years ago, would that patient be considered:

*1 New

*2 Established

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National Clinic or ED Guidelines

- CMS will not be implementing national visit guidelines for clinic or emergency department visits for CY 2009.
- Hospitals should continue to report visits during CY 2009 according to their own internal hospital guidelines.

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Type A ED Visits

- REVISED APC Code Titles
  - 0609 (Level 1 Type A ED Visit)
  - 0613 (Level 2 Type A ED Visit)
  - 0614 (Level 3 Type A ED Visit)
  - 0615 (Level 4 Type A ED Visit)

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Type B ED Visits

- **NEW APCs**
  - **0626 (Level 1 Type B ED Visit)**
    - **G0380**
  - **0627 (Level 2 Type B ED Visit)**
    - **G0381**
  - **0628 (Level 3 Type B ED Visit)**
    - **G0382**
  - **0629 (Level 4 Type B ED Visit)**
    - **G0383**

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Type A & B ED Visits

- **Shared APC assignment**
  - **0616 (Level 5 Emergency Visits)**
    - **G0384 (Level 5 Type B ED Visit)**
    - **99285 (Level 5 Type A ED Visit)**

NOTE: This is based upon the similar median costs for these visits.

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Partial Hospitalization Services

- **REVISED** patient eligibility criteria
  - Require minimum 20 hours per week of therapeutic services
  - Are likely to benefit from a coordinated program of services and require more than isolated sessions of outpatient treatment
  - Do not require 24-hour care

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Partial Hospitalization Services

- Have an adequate support system while not actively engaged in the program
- Have a mental health diagnosis
- Are not judged to be dangerous to self or others
- Have the cognitive and emotional ability to participate in the active treatment process and can tolerate the intensity of the program

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Notes/Comments/Questions

Partial Hospitalization Services

- NOW non-billable PHP CPT® codes
  - 90849
  - 90899
- CPT® codes replaced with HCPCS G-codes
  - 90853 replaced by G0410
  - 90857 replaced by G0411

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Inpatient List

- Procedures that comprise the "inpatient list" are services that are only paid when provided in an inpatient setting because of the nature of the procedure, the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged, or the underlying physical condition of the patient.

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CPT® Codes Removed from the Inpatient List

HCPCS Code	Long Descriptor	2009 APC	2009 SI
20660	Application of cranial tongs caliper, or stereotactic frame, including removal (separate procedure)	0138	T
21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)	0256	T
21386	Open treatment of orbital floor blowout fracture; periorbital approach	0256	T
21387	Open treatment of orbital floor blowout fracture; combined approach	0256	T
27479	Arrest, epiphyseal any method (eg, epiphysiodesis); combined distal femur proximal tibia and fibula	0050	T

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CPT® Codes Removed from the Inpatient List (cont'd)

HCPCS Code	Long Descriptor	2009 APC	2009 SI
43420	Closure of esophagostomy or fistula; cervical approach	0254	T
50727	Revision of urinary-cutaneous anastamosis (any type urostomy)	0165	T
51845	Abdomino-vaginal vesical neck suspension, with or without endoscopic control (eg, Stamey, Raz, modified Pereyra)	0202	T
51860	Cystorrhaphy, suture of bladder wound, injury or rupture; simple	0162	T
54332	One stage proximal penile or penoscrotal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap	0181	T

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CPT® Codes Removed from the Inpatient List (cont'd)

HCPCS Code	Long Descriptor	2009 APC	2009 SI
54336	One stage perineal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap	0181	T
54535	Orchiectomy, radical, for tumor, with abdominal exploration	0181	T

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Improvements to Prevention Services

- Initial Preventive Physical Exam Benefit
  - Waiving deductible
  - Extending eligibility period from 6 to 12 months
  - Screening EKG, referral process is payable

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Wound Care Services

- CPT® code 0183T is newly designated as a "sometimes therapy" service
  - Assigned to APC 0015
  - Qualifies for separate payment when performed independent of a therapy plan of care

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NEW! Payment Status Indicators

2008	2009
Indicators	
Q	Q1 Q2 Q3
N/A	R
N/A	U

These new status indicators will facilitate identification of the different categories of codes.

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Notes/Comments/Questions

NEW! Payment Status Indicators

Indicator	Item/Code/Service	OPPS Payment Status
Q1	STVX-Packaged Codes	Paid under OPPS (1)Packaged APC payment if billed on the same date of service as a HCPCS code assigned status indicator "S", "T", "V", or "X". (2)In all other circumstances, payment is made through a separate APC payment

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NEW! Payment Status Indicators

Indicator	Item/Code/Service	OPPS Payment Status
Q2	T-Packaged Codes	Paid under OPPS (1)Packaged APC payment if billed on the same date of service as a HCPCS code assigned status indicator "T". (2)In all other circumstances, payment is made through a separate APC payment.

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Notes/Comments/Questions

NEW! Payment Status Indicators

Indicator	Item/Code/Service	OPPS Payment Status
Q3	Codes That May Be Paid Through a Composite APC	Paid under OPPS (1)Composite APC payment based on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of service. (2)In all other circumstances, payment is made through a separate APC payment.

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NEW! Payment Status Indicators

Indicator	Item/Code/Service	OPPS Payment Status
R	Blood and Blood Products	Paid under OPPS; separate APC payment
U	Brachytherapy Sources	Paid under OPPS; separate APC payment

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Reporting Quality Data for Payment

- Hospitals and ASCs must submit data in the current CY on the specified Quality Measures to receive the full OPPS payment update for services furnished in the following CY.
- Any Hospital or ASC that fails to report data required for the quality measures will incur a reduction in their annual payment update factor by 2.0 percentage points.
- Any payment reduction would apply only to the payment year involved and would not be taken into account in computing the increase factor for a subsequent payment year.

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Polling Question #2

In 2008, did your facility submit data on the 7 designated quality measures?

*1 Yes

*2 No

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Notes/Comments/Questions

Will your facility receive the full OPPS payment update?

Quality Measure	
ED – AMI – 1	Aspirin at Arrival
ED – AMI – 2	Median Time to Fibrinolysis
ED – AMI – 3	Fibrinolytic Therapy Received within 30 Minutes of Arrival
ED – AMI – 4	Median Time to Electrocardiogram(ECG)
ED – AMI – 5	Median Time to Transfer for Primary PCI
PQRI # 20	Perioperative Care: Timing of Antibiotic Prophylaxis
PQRI #21	Perioperative Care: Selection of Perioperative Antibiotic

- Only those Hospitals that submitted data on the 7 designated measures effective with hospital outpatient services furnished on or after April 1, 2008 will receive the full OPPS payment update for services furnished in CY 2009.

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Hospitals that Failed to Meet the HOP QDRP Requirements

- Payment for all services assigned to status indicators “P”, “Q1”, “Q2”, “Q3”, “R”, “S”, “T”, “V”, or “X” would be subject to reduced payment.
  - This reduction would not apply to New Technology APCs
- Payments for these services will be based on a reduced market conversion factor (i.e., the reduced conversion factor).
  - Example:
    - CPT® code 11041, assigned to APC 0019, has a national unadjusted payment rate of $288.20. A Hospital that failed to meet the HOP QDRP requirements for CY 2009 payment would be reimbursed $282.72, the reduced national unadjusted payment rate.

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CY 2009 Quality Measures with CY 2010 Designations

2009	2010	Quality Measure
ED – AMI – 2	OP – 1	Median Time to Fibrinolysis
ED – AMI – 3	OP – 2	Fibrinolytic Therapy Received within 30 Minutes
ED – AMI – 5	OP – 3	Median Time to Transfer to Another Facility for Acute Coronary Intervention
ED – AMI – 1	OP – 4	Aspirin at Arrival
ED – AMI – 4	OP – 5	Median Time to ECG
PQRI #20	OP – 6	Timing of Antibiotic Prophylaxis
PQRI #21	OP – 7	Prophylactic Antibiotic Selection for Surgical Patients

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NEW! Imaging Measures

Quality Measure	
OP – 8	MRI Lumbar Spine for Low Back Pain
OP – 9	Mammography Follow-up Rates
OP – 10	Abdomen CT – Use of Contrast • OP-10: CT Abdomen – Use of Contrast Material • OP-10a: CT Abdomen – Use of Contrast Material excluding calculi of the kidneys, ureter, and/or urinary tract • OP-10b: CT Abdomen – Use of Contrast Material for diagnosis of calculi in the kidneys, ureter, and/or urinary tract
OP – 11	Thorax CT – Use of Contrast Material

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Addenda

Addendum	Title
Addendum A	APCs
Addendum B	Payment by HCPCS Code
Addendum D1	Payment Status Indicators
Addendum D2	Comment Indicators
Addendum E	HCPCS Codes Paid Only as Inpatient Procedures
Addendum M	HCPCS Codes Assigned to Composite APCs

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Resource Websites

- **Proposed Changes to the CY 2009 Hospital Outpatient Prospective Payment System**

  http://www.cms.hhs.gov/HospitalOutpatientPPS/HORD/list.asp#TopOfPage

- **Federal Register / Vol. 73, No. 223 / Tuesday, November 18, 2008 / Rules and Regulations**

  http://edocket.access.gpo.gov/2008/pdf/E8-26212.pdf

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Audience Questions

Audio Seminar Discussion

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January 15, 2009

Relative Value Unit (RVU) Data Analysis
January 22, 2009

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January 29, 2009

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Appendix

Resource/Reference List 34
CE Certificate Instructions

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