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Payment Matters®

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CMS Issues Final Outpatient PPS Regulations

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The Centers for Medicare and Medicaid Services (CMS) issued its final 2009 update for Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) payments on October 30, 2008. CMS will publish its final rules in the November 18th *Federal Register*, and those rules will become effective on January 1, 2009. A copy of these final rules can be obtained on the CMS web site **here**.

Key changes to the OPPS regulations include:

- ***Increase in OPPS Payments.***
  The 2009 conversion factor increased 2% and the market basket increased 3.6% from 2008. As a result, the total OPPS payments will increase by 3.9% in calendar year (CY) 2009.

- ***Updates to Quality Measures***
  - Four imaging efficiency measures were added, increasing the number of reportable quality measures from 7 in CY 2008 to 11 in CY 2009.
  - CMS is also seeking comments on 18 additional quality measures for CY 2011 and subsequent years.
  - Rather than randomly selecting hospitals for validating quality reporting as proposed, CMS adopted a voluntary test validation program for CY 2009. Results of this voluntary program will not affect CY 2010 payment updates.

- ***Ambulatory Payment Classification Updates (APC)***
  - In order to encourage imaging efficiency, CMS will no longer pay a full APC payment for each imaging procedure performed on the same date of service using the same imaging modality. Rather, hospitals will be paid a single composite payment for procedures in the same imaging family performed on the same date of service. The imaging composite APCs will be: ultrasound; CT and CTA without contrast; CT and CTA with contrast; MRI and MRA without contrast; and MRI and MRA with contrast.
  - Composite APC policies will continue for extended assessment and management, LDR prostate brachytherapy, cardiac

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electrophysiologic evaluation and ablation, and mental health services.

- New Technology services may continue to be classified as such until sufficient claims data is gathered to assign the services to a clinically appropriate APC.
- Existing methodology for setting payment rates for device-dependent APCs will be maintained.
- As a result of sufficient data collection, certain procedures will be moved from New Technology APCs to Clinical APCs.
- Existing rate setting methodology to set the payment rates for nuclear medicine procedures will be maintained.
- Two new rates for partial hospital programs (PHPs) were established.

- ***Updates to Hospital and Outpatient Visits***
  - CMS will continue to recognize new and established patient visit codes under the CY 2009 OPPS. In order to assist in distinguishing between new and established patients for purposes of correctly reporting clinic visits, CMS redefined 'established patient' as one who was registered as an inpatient or outpatient within the past three years.
  - CMS accepted APC Panel recommendations to assign separate APCs to the first four levels of Type B emergency department visits and assign level five to the same APC as level five of the Type A emergency department visit.
  - Hospitals must continue to report clinic and emergency department visits during CY 2009 according to hospitals' own internal guidelines.

- ***Outlier Policy Changes***
  - One percent of estimated aggregated total CY 2009 OPPS payments will be allocated for outlier payments.
  - Outlier payments will be made when the cost of furnishing a service exceeds 1.75 times the APC payment amount and exceeds the APC payment rate plus a $1,800 fixed-dollar threshold. The outlier payment will be equal to 50% of the amount by which the cost exceeds 3.40 times the APC payment rate.
  - To address vulnerabilities of the OPPS outlier payment system, CMS updated regulations to codify two existing OPPS outlier policies intended to ensure proper cost-to-charge (CCR) is utilized for outlier payment calculations. Additionally, CMS established two new regulations that further address payment vulnerabilities by minimizing a hospital's or Community Mental Health Center's ability to overestimate costs and receive inappropriately high outlier payments.

- ***Payment for Drugs and Biologicals***
  - Effective December 31, 2008, pass-through status for 15 drugs and biologicals will expire.
  - Implantable biologicals without pass-through status will be packaged into the payment for the associated surgical procedure.
  - A transitional payment rate of averages sales price (ASP) plus 4% will be paid for separately payable drugs and biologicals that submit ASP information through the existing ASP process.

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    - Single standard drug cost center will not be split into two cost centers.

- ***ASC Updates***
    - Fourteen newly designated surgical procedures are reimbursable when performed in an ASC.
    - Additional office-based procedures are now reimbursable under the Ambulatory Payment System.
    - Device intensive ASC procedures were updated to be consistent with device dependent APCs under the OPPS.
    - List of covered ancillary service updated to be consistent with updated list of covered ancillary services under the OPPS.
    - ASC payment rates revised to account for lower relative costs of ASC services and the budget neutrality requirement initiated in CY 2008.

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