SUMMARY OF THE FINAL CY 2006 MEDICARE HOSPITAL OUTPATIENT RULE

November 2005

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I. OVERVIEW

The Centers for Medicare and Medicaid Services (CMS) published the final Medicare Outpatient Prospective Payment System (OPPS) rule for calendar year (CY) 2006 in the November 10, 2005 *Federal Register*. Changes are effective January 1, 2005 unless otherwise noted. Each section of this summary indicates its location in the *Federal Register*.

Note: Text in italics is extracted from the *Federal Register*.

II. Ambulatory Payment Classification (APC) Payments

Conversion Factor

(*Federal Register* page 68551)

Background: Outpatient payment rates are determined by multiplying the relative weight for an APC by the conversion factor. The current 2005 conversion factor is $56.983.

CMS Proposal: *"The proposed market basket increase update factor of 3.2 percent for CY 2006, the required wage index budget neutrality adjustment of approximately 1.002015212, the return of 1.0 percent in total payments from a reduced outlier target, the 0.05 percent adjustment to the pass-through estimate, and the adjustment for the proposed rural payment adjustment of 0.99652023 result in a proposed conversion factor for CY 2006 of $59.350."*

CMS Final Rule: *"The market basket increase update factor of 3.7 percent for CY 2006, the required wage index budget neutrality adjustment of approximately 1.001485209, the return of 1.0 percent in total payments from a reduced outlier target, the return of 1.83 percent of the pass-through set-aside, and the adjustment for the rural payment adjustment of 0.99614506 result in a conversion factor for CY 2006 of $59.511."*

The marketbasket increase reflects a full update and is equal to the hospital inpatient marketbasket percentage increase. The budget neutrality adjustments to the conversion factor for wage index changes, the rural payment adjustment, the reduced outlier target, and the pass-through estimate are discussed in the relevant sections below.

Wage Index Adjustment

(*Federal Register* pages 68551 – 68553)

Background: To account for geographic differences, the labor portion of the conversion factor (60%) is adjusted by the hospital wage index. Currently, CMS applies the wage indexes used for the Inpatient PPS to the OPPS conversion factor. These wage indexes also apply to Tax Equity Fiscal Responsibility Act of 1982 (TEFRA) hospitals that participate in the OPPS, but not in the Inpatient PPS (IPPS).

CMS Proposal: *". . . we believed and continue to believe that using the IPPS wage index as the source of an adjustment factor for OPPS is reasonable and logical, given the inseparable, subordinate status of the hospital outpatient within the hospital overall."*

CMS Final Rule: CMS has adopted the above proposal as final with no revisions.

In 2005, CMS revised the wage areas based on Core-based Statistical Areas (CBSAs) as defined using data from the 2000 Census. This change had a significant redistributional impact, with many areas experiencing substantial increases or decreases in their wage adjustment. As a result, for both settings (inpatient and outpatient), CMS provided a one-year transition to the new wage areas for hospitals that were harmed by the redefinition. Hospitals that would have received a higher wage index under the prior geographic area definitions were given a blended wage index of 50% based on the new definitions and 50% based on the old definitions.

The OPPS will continue to use CBSAs to define labor market areas and the transition relief will expire for CY 2006.

In adopting the final federal fiscal year (FFY) 2006 Inpatient PPS wage indexes, the OPPS will apply all of the adjustments used in the IPPS including:

- an add-on to the wage index to reflect the commuting patterns of hospital employees who reside in a county and work in a different area with a higher wage index (the MMA Section 505 "out-migration" adjustment);
- a three-year transition for urban hospitals that became rural under the new labor area definitions that allows them to maintain their urban area assignment through 2007;
- recognition of all reclassifications, including the special one-time wage index reclassifications granted under Section 508 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003; and
- a 10% blend of the occupational mix adjustment to 10% of the average hourly wage used to calculate the wage index.

The final FFY 2006 inpatient PPS wage indexes to be used for the OPPS are shown on Table 1. The changes to the wage index will be implemented in a budget-neutral manner by increasing the conversion factor by approximately 0.15%.

Cost Outliers

(*Federal Register* pages 68561 - 68565)

Background: Outlier payments are made for individual services or procedures with extraordinarily high costs compared to the payment rates for their APC group. For the 2005 OPPS, outliers are defined as services with costs that exceed 1.75 times the APC payment rate and exceed the APC rate plus a $1,175 fixed-dollar threshold. This dual test was intended to eliminate outlier payments for low-cost services and provide higher outlier payments for more expensive procedures.

Currently, CMS sets a target for projected aggregate outlier payments at 2.0% of total OPPS payments. In the proposed rule, CMS cited the Medicare Payment Advisory Commission's (MedPAC) March 2004 report, which suggests Congress should eliminate the outlier policy under the OPPS. CMS states that, although elimination of outlier payments would require a statutory change, many of the reasons cited by MedPAC justify a reduction in the size of the outlier payment pool. MedPAC's March 2004 *Report to the Congress: Medicare Payment Policy* is available at http://www.medpac.gov/publications/congressional_reports/Mar04_Entire_reportv3.pdf

CMS Proposal: *"For CY 2006, we are proposing to set our projected target for aggregate outlier payments at 1.0 percent of aggregate total payments under OPPS . . . In order to ensure that estimated CY 2006 aggregate outlier payments would equal 1.0 percent of estimated aggregate total payments under OPPS, we are proposing that the outlier threshold be modified so that outlier payments are triggered when the cost of furnishing a service or procedure by a hospital exceeds 1.75 times the APC payment amount and exceeds the APC payment rate plus a $1,575 fixed dollar threshold."*

CMS Final Rule: CMS has adopted the above proposal as final. Based on the use of a complete set of 2004 claims data, the fixed-dollar threshold has been lowered by $325 from the proposed rule to $1,250.

As proposed, CMS is reducing the target for projected aggregate outlier payments from 2.0% to 1.0%. This change to reduce the outlier pool by 1.0% will be implemented in a budget-neutral manner by increasing the conversion factor by 1.0%. CMS will continue to pay 50% of the amount by which the cost of furnishing the service exceeds 1.75 times the APC payment rate when the cost of a hospital outpatient service exceeds these thresholds.

Transitional Corridor Payments

(*Federal Register* pages 68555 - 68556)

Background: When the OPPS was implemented, transitional corridor payments were established to provide relief to hospitals that would receive less in payments under the OPPS methodology than they would have received under the prior payment system. Rural hospitals with 100 or fewer beds, cancer hospitals, and children's hospitals were held harmless and paid the full amount of the difference between the OPPS and the prior payment system. Other hospitals were eligible for partial relief. For most hospitals, the transitional corridor payments were set to expire on December 31, 2003. The MMA extended transitional corridor payments through December 31, 2005 for rural hospitals with 100 or fewer beds and provided transitional corridor payments during the same period for Sole Community Hospitals (SCHs) located in rural areas. Cancer hospitals and children's hospitals are permanently held harmless from the impact of the OPPS.

CMS Proposal: *"Accordingly, the authority for making transitional corridor payments under section 1833(t)(7)(D)(i) of the Act, as amended by section 411 of Pub. L. 108-173, will expire for rural hospitals having 100 or fewer beds and sole community hospitals located in rural areas on December 31, 2005. For CY 2006, transitional corridor payments will continue to be available to cancer and children's hospitals."*

CMS Final Rule: CMS has adopted the above proposal as final with no revisions.

Rural Hospital Adjustment

(*Federal Register* pages 68556 - 68561)

Background: The same provision of the MMA that called for an extension of the transitional corridor payments also required CMS to conduct a study to determine if the cost of providing outpatient care in rural hospitals exceeds the cost in urban hospitals. The MMA requires that CMS provide an appropriate adjustment to rural hospitals by January 1, 2006 if the study proves it is warranted.

CMS Proposal: *"Thus, in accordance with the authority provided in section 1833(t)(13)(B) of the Act, as added by section 411 of Pub. L. 108-173, we are proposing a 6.6 percent payment increase for rural SCHs for CY 2006. This adjustment would apply to all services and procedures paid under the OPPS, excluding drugs and biologicals. We note that this adjustment would be budget neutral, and would be applied before calculating outliers and coinsurance. We may revisit this adjustment in the future."*

CMS Final Rule: CMS has adopted the above proposal as final. Based on the use of a complete set of 2004 claims data, the payment increase provided for rural SCHs is 7.1%; this is 0.5% higher than proposed.

CMS does <u>not</u> propose any payment adjustment for other rural hospitals. Overall, CMS' analysis shows that all rural hospitals give some indication of having higher cost per unit. However, CMS found that rural SCHs demonstrated significantly higher cost per unit than urban hospitals. The provision of a 7.1% payment increase for rural SCHs will be implemented in a budget-neutral manner, reducing the conversion factor by 0.39%.

Recalibration of APC Weights

(*Federal Register* pages 68523 - 68547)

Background: CMS is required to review and revise the APC relative payment weights at least annually. CMS calculated the APC weights for 2005 using claims for services furnished on or after January 1, 2003 and before January 1, 2004.

CMS Proposal: *"We are proposing that the APC relative payment weights for CY 2006 under the OPPS would continue to be based on the median hospital costs for services in the APC groups. For the CY 2006 OPPS final*

rule, we are proposing to base APC median costs on claims for services furnished in CY 2004 and processed before June 30, 2005."

CMS Final Rule: CMS has adopted the above proposal as final with no revisions. The APC relative weights and payments can be found in Addenda A and B posted on the CMS Web site at: http://www.cms.hhs.gov/providers/hopps/2006fc.

III. Transitional Pass-Through Payments

Pass-Through Spending

(*Federal Register* pages 68673 - 68674)

Background: The Balanced Budget Refinement Act of 1999 (BBRA) provided transitional pass-through payments for certain drugs, pharmaceuticals, biologicals, and medical devices. Per the final CY 2006 OPPS rule, the number of drugs and devices paid as pass-throughs will change as shown below:

APC Category	Status	2005	Expirations	Additions	Net 2006
New Drugs and Biologicals	G	29	10	0	19
Medical Devices	H	3	3	0	0
Total		**32**	**13**	**0**	**19**

The net decrease in transitional pass-through payment APCs reflects the expiration of some payments and the inclusion of no new categories. CMS capped the total amount of pass-through spending at 2.0% of total OPPS payments for CY 2006. However, CMS estimates that total pass-through spending for drug and device categories will only equal 0.17% of total OPPS payments. This estimate reflects the determination by CMS that the incremental cost of pass-through payments for drugs will be zero for CY 2006. Per the MMA, CMS will continue to make separate payments for new drugs and biologicals based on the Average Sale Price (ASP)+6%, regardless of whether the drug is granted pass-through status or not (see below). Therefore, the pass-through amount for new drugs is equal to the amount that would otherwise be paid. Hence, there is no carve-out for new drug and biological pass-through payments. The 0.17% is an estimate for device categories that may become eligible for pass-through status in CY 2006 after publication of the proposed rule.

CMS Proposal: *"Because we estimate pass-through spending in CY 2006 would not amount to 2.0 percent of total projected OPPS CY 2006 spending, we are proposing to return 1.95 percent of the pass-through pool to adjust the conversion factor . . . ."*

CMS Final Rule: *". . . we are finalizing our proposed methodology for estimating CY 2006 OPPS pass-through spending for drugs, biologicals, and categories of devices . . . this proposal as modified will return 1.83 percent of the pass-through pool to adjust the conversion factor."*

Payment for Pass-Through Devices

(*Federal Register* pages 68626 - 68631)

The law limits payments for pass-through devices to between two and three years. It has been CMS' policy to remove devices from pass-through status as quickly as possible and most are incorporated into the APC rates after two years. CMS will retire the current three pass-through devices after December 31, 2005. These items will be treated as packaged items with no separate payment in CY 2006. Instead, the cost for these devices will be incorporated into the rates of their associated procedure APCs. CMS has not identified any new pass-through devices for CY 2006.

Payment for Pass-Through Drugs, Biologicals, and Radiopharmaceuticals

(*Federal Register* pages 68631 - 68635)

Background: The MMA requires pass-through drugs to be paid at the ASP+6% for 2005 and thereafter. The ASP drug payment system is based on data submitted by manufacturers. The ASP data that CMS uses to calculate the pass-through payment is updated quarterly.

CMS Proposal: *"We are proposing to continue pass-through status in CY 2006 for 14 drugs and biologicals . . . Similar to the payment policy established for pass-through drugs and biologicals in CY 2005, we are proposing to pay under the OPPS for drugs and biologicals with pass-through status in CY 2006 consistent with the provisions of section 1842(o) of the Act, as amended by section 621 of Pub. L. 108–173, at a rate that is equivalent to the payment these drugs and biologicals would receive in the physician office setting."*

CMS Final Rule: CMS has adopted the above proposal as final with no revisions.

It has been CMS' policy to remove a drug's pass-through status as quickly as possible and most are incorporated into the APC rates after two years. The final rule identifies ten drugs whose pass-through status will expire on December 31, 2005. For CY 2006, nine of these drugs will be paid in separate APCs, and one will be treated as a packaged item with no separate payment.

Fourteen drugs that had pass-through status in CY 2005 will still be eligible for pass-through payments in CY 2006; three additional drugs were granted pass-through status as of July 1, while two additional drugs were approved for pass-through status as of October 1. Payment rates for these drugs are included in the final rule; no additional drugs have been granted pass-through status for 2006. There has been no methodology change in payment for pass-through drugs from 2005.

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

Payment for Drugs, Biologicals, and Radiopharmaceuticals—Packaging Criteria

(*Federal Register* pages 68635 - 68638)

Background: The costs of drugs, biologicals, and radiopharmaceuticals are generally packaged into the APC rate for their related procedures or services, unless they are determined to be relatively expensive or are rarely used. Items such as single indication orphan drugs, certain vaccines, and blood and blood products are excluded from the packaging policy.

CMS Proposal: *". . . we are proposing to continue our existing policy of paying separately for drugs, biologicals, and radiopharmaceuticals whose per day cost exceeds $50 and packaging the cost of drugs, biologicals, and radiopharmaceuticals whose per day cost is less than $50 into the procedures with which they are billed . . . . We are also proposing to continue our policy of exempting the oral and injectible 5HT3 anti-emetic products from our packaging rule . . . thereby making separate payment for all of the 5HT3 anti-emetic products."*

CMS Final Rule: CMS has adopted the above proposal as final with no revisions.

CMS will continue payment for drugs over the $50 threshold at ASP+6% unless deemed payable under an alternative methodology as indicated below. The $50 threshold for establishing separate APCs for drugs and biologicals will expire at the end of CY 2006. CMS solicited comments and will be evaluating alternative packaging criteria for drugs and radiopharmaceuticals in CY 2007.

Payment for Specified Covered Outpatient Drugs

(*Federal Register* pages 68639 - 68657)

Background: The MMA established a class of drugs called "specified covered outpatient drugs." These are defined as any existing covered outpatient drug, biological, or radiopharmaceutical agent for which a separate APC exists and, in the case of drugs and biologicals, payment was made on a pass-through basis on or before December 31, 2002. Pass-through status for these drugs had expired and they were paid non-pass-through APC rates. For CYs 2004 and 2005, the MMA required that payment for these drugs be based on a reference average wholesale price (AWP), increasing rates for these drugs.

The MMA requires that payment for specified covered outpatient drugs in CY 2006 be equal to the average acquisition cost for the drug for that year as determined by the Secretary of Health and Human Services (HHS), subject to any adjustment for overhead costs and taking into account the hospital acquisition cost survey data collected by the General Accounting Office (GAO) in 2004 and 2005. CMS analyzed three different data sources to determine "average" acquisition cost: GAO mean purchase price survey data, fourth quarter ASP data, and mean costs from CY 2004 claims data.

CMS Proposal: *"We are proposing to pay ASP+6 percent for separately payable drugs and biologicals in CY 2006. Given the data . . . we believe this is our best estimate of average acquisition costs for CY 2006."*

CMS Final Rule: CMS has adopted the above proposal as final with no revisions.

This payment policy will be applied to specified covered outpatient drugs as well as to drugs determined to be separately payable because their cost per day exceeds $50. CMS will use ASP data from the second quarter 2005 as the basis for setting payment rates in the final rule, but will update these rates quarterly.

CMS does not have ASP data for radiopharmaceuticals and will determine their packaging status by using costs per day, which will be calculated from hospitals' CY 2004 claims data. For radiopharmaceuticals that are determined to be separately payable, CMS has finalized its proposal of a temporary, one-year payment policy based on hospitals' charges for each radiopharmaceutical adjusted to cost using hospitals' overall Cost-to-Charge Ratio (CCR).

In addition, CMS further proposed to begin collecting ASP data on all radiopharmaceutical agents to implement ASP-based payment for radiopharmaceuticals beginning in CY 2007. CMS is not adopting this proposal in the final rule. Instead, CMS states that it will continue to explore ASP reporting and alternatives to ASP reporting in an attempt to establish an appropriate payment methodology for CY 2007.

Additional Payment for Drugs and Biologicals to Account for Pharmacy Overhead Costs

(*Federal Register* pages 68657 - 68665)

Background: The MMA required the Medicare Payment Advisory Commission (MedPAC) to submit a report to the HHS Secretary on adjusting the APC rates for specified covered outpatient drugs to take into account overhead and related expenses, such as pharmacy services and handling costs. The provision, among other things, required a recommendation as to whether a payment adjustment should be made and the methodology for adjusting payment, if an adjustment is recommended.

MedPAC concluded that the handling costs for drugs, biologicals, and radiopharmaceuticals delivered in the hospital outpatient department are significant, as medications administered in outpatient departments generally require greater pharmacy preparation time than do those provided to inpatients. The MedPAC analysis found that, although little information is currently available about the magnitude of these costs, hospitals historically set charges for drugs, biologicals, and radiopharmaceuticals at levels that reflect the respective handling costs and that payments covered both drug acquisition and handling. MedPAC therefore recommended that CMS:

- establish separate, budget-neutral payments to cover the handling costs hospitals incur for separately payable drugs, biologicals, and radiopharmaceuticals; and

- define a set of handling fees for APCs, grouping drugs, biologicals, and radiopharmaceuticals based on attributes of the products that affect handling costs; instruct hospitals to submit charges for these new APCs; and base payment rates for these APCs on submitted charges reduced to costs.

CMS Proposal: *". . . we are proposing for CY 2006 to pay for drug and biological overhead costs based on 2 percent of the ASP . . . . Moreover, as we are proposing to pay for all separately payable drugs and biologicals using the ASP methodology, where payment rates for most of these items are set at the ASP+6 percent, we believe that an additional 2 percent of the ASP would provide adequate additional payment for the overhead cost of these products and be consistent with historical hospital costs for drug acquisition and handling"*

"As a MedPAC survey of hospital charging practices indicated that hospitals' charges for drugs, biologicals, and radiopharmaceuticals reflect their handling costs as well as their acquisition costs, we believe pharmacy overhead costs would be incorporated into the OPPS payment rates for drugs, biologicals, and radiopharmaceuticals if the rates are based on hospital claims data. However, in light of our proposal to establish three distinct C-codes for drug handling categories, we are proposing to instruct hospitals to charge the appropriate pharmacy overhead C-code for overhead costs associated with each administration of each separately payable drug and biological based on the code description which best reflects the service the hospital provides to prepare the product for administration to a patient. We would then collect hospital charges for these C-codes for 2 years, and consider basing payment for the corresponding drug handling APCs on the charges reduced to costs in CY 2008, similar to the payment methodology for other procedural APCs. Median hospital costs for the drug handling APCs should reflect the CY 2006 practice patterns across all OPPS hospitals of handling drugs whose preparation is described by each of the C-codes, reflecting the differential utilization of various forms of drugs and alternative methods of preparation and delivery through hospitals' billing and charges for the C-codes."

CMS Final Rule: CMS has not adopted the above proposal.

"In light of the extensive operational issues related to coding, billing, and charging for C-codes for drug handling categories identified by commenters, we believe there is good reason at this time not to proceed with our proposal for CY 2006. Therefore, we are not finalizing our proposal to collect data on pharmacy overhead costs in CY 2006. Rather, we will continue to solicit input from the industry, APC Panel, and hospitals to explore alternative methodologies for capturing meaningful and complete pharmacy overhead costs, for potential use in providing appropriate payments to hospitals for such services in future updates of the OPPS."

The proposed 2% add-on to account for pharmacy overhead costs was to be implemented in a budget-neutral manner. Therefore, because this proposal was not included in the final rule, the 2% set aside for this adjustment will be returned to the conversion factor in the final rule.

CMS did not propose to create separate handling categories for radiopharmaceutical agents in CY 2006. Instead, as discussed above, payment for radiopharmaceuticals in 2006 will be made based on hospital charges converted to costs. CMS is encouraging hospitals to include in their charges, all costs associated with the acquisition, preparation, and handling of these products so that their payments under the OPPS can accurately reflect all of the actual costs associated with providing these products to hospital outpatients.

Payment for New Drugs, Biologicals, and Radiopharmaceuticals before HCPCS Codes are Assigned

(*Federal Register* page 68669)

Background: After the Food and Drug Administration (FDA) has approved a drug, a period passes before it is assigned a Healthcare Common Procedure Coding System (HCPCS) code and becomes eligible for pass-through payment. Currently, for hospitals to bill and receive payment for a drug or biological that is newly approved by the FDA, hospitals report the National Drug Code (NDC) for the product along with HCPCS Code C9399: unclassified drug or biological. When C9399 appears on a claim, it is suspended for manual pricing by the fiscal intermediary (FI). The FI prices the claim at 95% of its AWP.

CMS Proposal: *"For CY 2006, we are proposing to continue the same methodology for paying for new drugs, biologicals, and radiopharmaceuticals without HCPCS codes."*

CMS Final Rule: CMS has adopted the above proposal as final with no revisions.

Payment for Vaccines

(*Federal Register* pages 68669 - 68670)

Background: In CY 2003, CMS established payments for influenza and pneumococcal vaccines based on reasonable costs. This was in response to concerns about yearly fluctuations in the cost of the flu vaccine. However, hepatitis B vaccines have been paid under clinical APCs that include other vaccines. Payment rates for these APCs were based on median costs, calculated from the costs of all the vaccines grouped within the APCs.

CMS Proposal: *"We are proposing to continue to pay influenza and pneumococcal vaccines at reasonable cost in CY 2006 . . . we are proposing to pay for all hepatitis B vaccines at reasonable cost . . . ."*

CMS Final Rule: CMS has adopted the above proposal as final with no revisions. In addition to paying for influenza, pneumococcal pneumonia, and hepatitis B vaccines at reasonable cost, CMS will pay for each separately payable vaccine under its own APC as a first step toward eventually establishing payment rates for these vaccines based on the ASP.

Payment for Orphan Drugs

(*Federal Register* pages 68670 - 68673)

Background: "Orphan" drugs are expensive drugs that, by definition, are rarely used. CMS has recognized that packaging these drugs into procedure APCs would result in payments insufficient to cover their cost and therefore, established separate APC payments for these drugs. For CY 2005, CMS pays for 14 orphan drugs at the higher of 88% of the AWP or 106% of the ASP, with a cap of 95% of the AWP.

CMS Proposal: *". . . for CY 2006, we are proposing to pay for single indication orphan drugs at the ASP+6 percent. We believe that paying for orphan drugs using the ASP methodology is consistent with our proposed general drug payment policy for other separately payable drugs and biologicals in the CY 2006 and reflects our general view that ASP-based payment rates serve as the best proxy for the average acquisition cost for these items . . . . In addition, we are proposing to pay an additional 2 percent of the ASP scaled for budget neutrality to cover the handling costs of these drugs, also consistent with our proposed general pharmacy overhead payment policy for handling costs associated with separately payable drugs and biologicals."*

CMS Final Rule: CMS has revised the above proposal slightly. As discussed above, CMS has not implemented its proposal to pay an additional 2% of the ASP to cover pharmacy overhead costs. Therefore, payment for orphan drugs will be made at the ASP+6% and will not include an additional 2% of ASP to cover handling costs as proposed. Payment rates based on ASPs will be updated quarterly.

V. APC Group Changes

The final rule revises the APC groups to take into account drugs and devices that no longer qualify for pass-through status, new and deleted HCPCS/Current Procedural Terminology (CPT) codes, changes in technologies, new services, and new cost data. In addition, the final rule includes input from the Advisory Panel on APC Groups (APC Panel)—an outside panel of experts established by the Balanced Budget Act (BBA) of 1997. For a complete discussion of APC group changes, please click on the following links:
Federal Register pages 68523 - 68547 and *Federal Register* pages 68566 – 68618.

APCs for Services Other than Pass-Throughs
Number of APC Groups by Category

APC Category	Status Indicator	2004	2005	2006
Medical Visits	V	6	6	6
Surgical Procedures	T	203	208	208
Significant Procedures	S	123	123	128
Ancillary Services	X	43	44	46
Drugs/Biologicals	K	251	315	292
Brachytherapy Sources/Seperately Payable Radiopharmaceuticlas Paid at Cost	H	7	11	55
Partial Hospitalization	P	1	1	1
Observation	Q	0	0	1
New Technology	S/T	74	74	82
Total		**708**	**782**	**819**

New Technology APCs

(*Federal Register* pages 68571 - 68572)

Background: In 2002, CMS created New Technology APCs as a means to pay for new services and devices that were not represented in the 1996 base-year data and did not meet the transitional payment pass-through criteria. A new procedure is assigned to a new technology APC until such time as enough data are collected to allow assignment to a clinically appropriate APC. In CY 2004, CMS established payment levels for these new technology APCs in $50, $100, and $500 intervals. According to CMS, as the number of procedures that qualify for placement in the New Technology APCs has continued to increase over the past two years, the $0 to $50 cost category spans too broad of a cost interval to accurately represent the lower costs of an ever increasing number of procedures that qualify for New Technology payment.

CMS Proposal: *". . . we are proposing to refine this cost band to five $10 increments, resulting in the creation of an additional 10 New Technology APCs to accommodate the two parallel sets of New Technology APCs, one set with a status indicator of ''S'' and the other set with a status indicator of ''T.'' We are also proposing to eliminate the two $0 to $50 cost band New Technology APCs . . . ."*

CMS Final Rule: CMS has adopted the above proposal as final with no revisions.

Device-Dependent APCs

(*Federal Register* pages 68618 - 68625)

Background: CMS defines device-dependent APCs as procedures that usually cannot be provided without one or more devices. These procedures include insertion of a pacemaker; diagnostic cardiac catheterization; and brachytherapy. Many of the devices involved were once paid as pass-throughs, but are now packaged with the procedure APC.

CMS has consistently experienced problems determining payment rates for procedures that include devices. For the past three years, when using claims data to calculate APC rates for these procedures, the resulting rates were often substantially less than the cost of the device alone. In CYs 2003 and 2004, CMS determined that many hospitals were not consistently reporting charges for the devices. In response, CMS limited the APC median cost calculation to claims that included a separate charge for the device, and placed limits on rate decreases for these APCs. Because CMS eliminated the HCPCS codes for devices in 2003, it was impossible in 2005 to follow past practice and limit the calculation to claims with device charges. Therefore, in 2005 CMS determined rates for device-dependent APCs to be the greater of median costs calculated using CY 2003 claims data or 95% of the APC payment median for CY 2004.

CMS Proposal: *". . . for the CY 2006 OPPS, as we have consistently done for device-dependent APCs, we are proposing to adjust the median costs for the device-dependent APCs. . . for which comparisons with prior years are valid to the higher of the CY 2006 unadjusted APC median or 85 percent of the adjusted median on which payment was based for the CY 2005 OPPS."*

CMS Final Rule: CMS has revised the above proposal.

"After considering all of the comments received, we have set the median costs for device-dependent APCs for CY 2006 at the highest of: The median cost of all single bills; the median cost calculated using only claims that contain pertinent device codes and for which the device cost is greater than $1; or 90 percent of the payment median that was used to set the CY 2005 payment rates We set 90 percent of the CY 2005 payment median as a floor in consideration of comments that stated that a 15-percent reduction from the CY 2005 payment median was too large of a transitional step. We also incorporated, as part of our methodology, the recommendation to base payment on medians that were calculated using only claims that passed the device edits. We believe that this policy provides a reasonable transition to full use of claims data in CY 2007, while better moderating the amount of decline from the CY 2005 OPPS payment rates."

Out of the 39 device-dependent APCs identified by CMS for CY 2006, rates increased by an average of 10.6%. CMS has identified one new device-dependent APC for 2006.

CMS is currently requiring hospitals to include device category codes ("C"-codes) when billing for any of the select device-dependent APCs paid under the OPPS. The reporting of "C"-codes was required effective January 1, 2005; however, CMS did not implement edits until April 1, 2005. CMS expects to be able to use the unadjusted median costs for device-dependent APCs as the basis of its payment weights for the CY 2007 OPPS because 2005 claims should more accurately reflect the costs of devices used to provide services.

VI. Multiple Diagnostic Imaging Procedures

(*Federal Register* pages 68703 - 68708)

Background: Currently, hospitals receive full APC payments for each diagnostic imaging procedure on a claim, regardless of how many are performed using a single imaging modality and whether or not contiguous areas of the body are studied in the same session.

In its March 2005 Report to Congress, available at: http://www.medpac.gov/publications/congressional_reports/Mar05_EntireReport.pdf, MedPAC recommended an improvement to Medicare coding edits that would detect unbundled diagnostic imaging services and reduce the technical component payment for multiple imaging services when they are performed on contiguous areas of the body. Currently, payment rates are based on each service being provided independently and the rates do not account for efficiencies that may be gained when multiple studies using the same imaging modality are performed in the same session.

For surgical procedures, the OPPS has a longstanding policy of reducing payment for multiple procedures performed on the same patient in the same operative session. In such cases, full payment is made for the

procedure with the highest APC payment rate, and each subsequent procedure is paid at 50% of its respective APC payment rate.

CMS Proposal: *". . . we are proposing to make a 50-percent reduction in the OPPS payments for some second and subsequent imaging procedures performed in the same session, similar to our policy of reducing payments for some second and subsequent surgical procedures. We are proposing to apply the multiple imaging procedure reduction only to individual services described by codes within one Family, not across Families. Reductions would apply when more than one procedure within the Family is performed in the same session. For example, no reduction would apply to an MRI of the brain (CPT code 70552) in code Family 5, when performed in the same session as an MRI of the spinal canal and contents (CPT code 72142) in code Family 6. We are proposing to make full payment for the procedure with the highest APC payment rate, and payment at 50 percent of the applicable APC payment rate for every additional procedure, when performed in the same session."*

CMS identified 11 "Families" of imaging procedures by imaging modality. Using those Families of procedures, CMS examined OPPS bills for CY 2004 and found numerous instances of claims reporting more than one imaging procedure within the same Family, for a single session. When multiple images are acquired in a single session, most of the clinical labor activities are not performed twice and many of the supplies are not furnished twice. Therefore, CMS believed that reducing the payment for the second and subsequent procedures within the identified Families would result in more accurate payments with respect to the hospital resources used for multiple imaging procedures performed in the same session.

CMS Final Rule: CMS has not adopted the above proposal.

"After careful consideration of the public comments received, the results of additional analyses of CY 2004 OPPS claims data, and the APC Panel recommendation, we have decided not to finalize our proposal to discount for multiple diagnostic imaging procedures at this time. . . our analyses do not disprove the commenters' contentions that there are efficiencies already reflected in their hospital costs, and therefore, their CCRs and the median costs for the procedures. Further, the results of our initial analyses do support the recommendation that we should defer implementation of the proposed multiple imaging procedure reduction policy to perform additional analyses. Depending upon the results of our analyses, in a future rule we may propose revisions to the structure of our rates in order to ensure that these rates properly reflect the relative costs of initial and subsequent imaging procedures."

VII. Interrupted Procedure Payment

(*Federal Register* pages 68708 - 68711)

Background: Hospitals are required to report modifiers -52, -73, and -74 to indicate procedures that were terminated before their completion. Modifier -52 indicates partial reduction or discontinuation of services that do not require anesthesia. Modifiers -73 and -74 are used for procedures requiring anesthesia, where the patient was taken to the treatment room and the procedure was discontinued before anesthesia administration or after anesthesia administration/procedure initiation respectively. The elective cancellation of procedures is not reported. Hospitals are paid 100% for procedures with modifier -52 or -74 and 50% of the APC payment for services with modifier -73.

Based on an analysis of CY 2004 hospital claims data, modifier -52 is reported most often to identify interrupted or reduced radiological and imaging procedures. CMS is skeptical that it is accurate to pay the full APC rate for a discontinued or reduced radiological service while making only 50% of the APC payment for surgical procedures requiring anesthesia which generally require greater resources.

CMS Proposal: *". . . we are proposing to pay 50 percent of the APC payment amount for a discontinued procedure that does not require anesthesia where modifier -52 is reported. We believe that this proposed payment would appropriately recognize the hospital's costs involved with the delivery of a typical reduced service, similar to our payment policies for interrupted procedures that require anesthesia."*

CMS Final Rule: CMS has adopted the above proposal as final with no revisions.

CMS did not propose any changes to modifiers -73 and -74. Although the APC Panel had recommended that modifier -73 be paid the full APC amount based on the resources needed for the procedure, CMS believes hospitals realize significant savings when procedures are discontinued prior to initiation and will continue to pay 50% of the procedure's APC payment when modifier -73 is reported. CMS sought comment on the potential reduction of the APC payment amount for procedures reported with modifier -74. CMS believes there is cost savings when a procedure is discontinued regardless of the administration of anesthesia, and may further examine cost data regarding this modifier.

VIII. Other

Partial Hospitalization

(*Federal Register* pages 68547 - 68551)

Background: Partial hospitalization is an intensive outpatient psychiatric program provided to patients in place of inpatient psychiatric care. A partial hospitalization program (PHP) may be provided by a hospital to its outpatients or by a freestanding Community Mental Health Center (CMHC). OPPS providers are paid on a per-diem basis for partial hospitalization services.

Generally, CMS is required to establish relative payment weights based on median costs. Historically, the median per-diem cost for CMHCs has greatly exceeded the median per-diem cost for hospital-based PHPs. CMS indicates that hospital-based PHPs are Medicare providers that are required to maintain uniform charges for all payers and therefore, are less likely to significantly change their charges for PHP from year to year, while many CMHCs have indicated that Medicare is their only payer and as a result may have increased and decreased their charges in response to Medicare payment policies including the manipulation of charges to inappropriately receive outlier payments.

As a result, there has been a significant fluctuation in the CMHC median per-diem cost, including significant decreases in both 2005 and 2006, while hospital-based median per-diem costs have remained relatively stable. CMS considered several alternatives to mitigate this drastic reduction.

CMS Proposal: "*For CY 2006, we are proposing to apply a 15-percent reduction in the combined hospital-based and CMHC median per diem cost that was used to establish the CY 2005 PHP APC. That amount would then be scaled to be relative to the cost of a midlevel office visit to establish the PHP APC for CY 2006. . . . To apply the methodology, we would reduce $289 (the CY 2005 combined hospital-based and CMHC median per diem cost) by 15 percent, resulting in a combined median per diem cost of $245.65. After scaling, we are proposing the resulting APC amount for PHP of $240.51 for CY 2006, of which $48.10 is the beneficiary's coinsurance. We will continue to analyze the data to determine whether there is a more targeted approach that would allow use of the CMHC and hospital PHP claims data to establish the final PHP rate for CY 2006.*"

CMS Final Rule: CMS has adopted the above proposal as final. The final payment rate for PHP is set at $246.04 for 2006.

CMS establishes a separate outlier threshold for PHP payments to CMHCs. The threshold for 2006 is 3.4% times the APC payment amount. Payment to CMHCs for outliers will be made at 50% of the costs in excess of the threshold.

Brachytherapy Payment

(*Federal Register* pages 68674 - 68676)

Background: The MMA requires that all devices of brachytherapy consisting of a seed or seeds (or radioactive source) be paid based on a facility's charges for the service, adjusted to cost. This provision is effective for services furnished from January 1, 2004 through December 31, 2006. In addition, because brachytherapy sources are paid at cost, they are excluded from outlier payments and from any budget neutrality requirements. To accommodate this MMA requirement, CMS revised the status codes for brachytherapy sources to "H" and revised the definition of status code "H" to include non-pass-through brachytherapy sources paid on a cost basis.

CMS Proposal: *". . . we are not proposing any coding changes to the sources of brachytherapy for CY 2006 at this time."*

CMS Final Rule: CMS did not address any additional issues regarding brachytherapy payment in the final rule.

The MMA requires GAO to conduct a study to determine appropriate payment amounts for devices of brachytherapy beyond December 31, 2006. GAO is to submit a report on its study to the Congress and the HHS Secretary, including recommendations. CMS is awaiting this report.

Drug Administration—Payment and Coding

(*Federal Register* pages 68676 - 68681)

Background: In CY 2004, CMS proposed to change the coding and payment for drug administration in an attempt to pay more accurately for the wide range of services and drugs that are packaged into these per-visit codes. The proposal was not implemented at that time, but CMS stated that it would reconsider it for CY 2005. For CY 2005, CMS replaced the HCPCS Q codes with CPT codes for drug administration, and cross-walked these CPT codes to the APCs that reflect how the services would have been paid under the old Q codes.

CMS Proposal: *"For CY 2006 OPPS billing purposes, we are proposing to continue our policy of using CPT codes to bill for drug administration services provided in the hospital outpatient department. We anticipate that the current CPT codes will no longer be effective in CY 2006, and, therefore, we are proposing a CY 2006 crosswalk that maps current CPT codes to the CPT drug administration codes approved by the CPT Editorial Panel in 2004, which correspond to the G-codes used in the physician office setting for CY 2005 and which we expect to become active CPT codes for 2006."*

CMS Final Rule: CMS has adopted the above proposal as final with the following modifications quoted below. Please see the above link for a complete discussion of the final implementation of the above proposed policy and tables referenced in the text excerpt below. CMS will release instructions providing drug administration billing and coding guidance for hospitals for CY 2006.

". . .we will be adopting 20 of the 33 CY 2006 drug administration CPT codes for billing and payment purposes under the OPPS for CY 2006 (Table 29). In addition, we will not recognize under the OPPS 13 of the 33 CY 2006 CPT codes, but instead will instruct hospitals to use 6 new HCPCS C-codes for billing and payment purposes under OPPS for CY 2006 (Table 31). The C-codes generally parallel the less complex CY 2005 CPT codes for infusions and intravenous pushes, as those codes will be deleted for the CY 2006 OPPS. We are adopting these 6 newly created C-codes in an effort to minimize the administrative burden hospitals have indicated they will face if the OPPS were to adopt all 33 of the CY 2006 drug administration CPT codes."

Hospital Coding for Evaluation and Management (E/M) Services

(*Federal Register* pages 68683 - 68684)

Background: Emergency and clinic visits are paid based on three levels of service: low, mid, and high. The level is determined by the reported evaluation and management (E/M) CPT code. There is currently no uniform

policy to determine which E/M code should be used. Instead, each hospital creates a set of internal guidelines for determining the proper level of service. If it develops and follows guidelines, a hospital is considered in compliance with OPPS coding requirements.

CMS continues to work on a proposal and has not yet made plans for implementation of uniform coding guidelines. CMS intends to make their proposal available for public comment and anticipates providing at least six to 12 months notice to allow for training and system changes.

Blood and Blood Product Payment

(*Federal Register* pages 68684 - 68688)

Background: CMS pays for blood and blood products under the OPPS through separate APC payments rather than packaging these products into the APCs for the procedures with which they are administered. Generally, CMS prefers to use Medicare claims data when setting payment rates, but has had problems establishing rates for blood and blood products. Since the implementation of the OPPS, payment rates for blood and blood products have been based on external data, due to limited Medicare claims data. CY 2000 rates were based on external data, which were then trended forward to 2001 and 2002. These rates were reduced, subject to limits, in CY 2003 and payments were frozen at the CY 2003 level in CY 2004.

For CY 2005, CMS continued to pay for blood and blood products separately and established new APCs for each blood product. For the first time, payment rates for blood and blood products were based on claims data (CY 2003 claims data), utilizing an actual or simulated hospital blood-specific CCR to convert charges to costs. Simulated CCRs were used in cases where CMS experienced problems with the reported claims data. In applying this new methodology, the simulated median costs for those procedures that require a low volume of blood units (less than 1,000 per year) showed large decreases compared to CY 2004. For these low-volume blood products, the CY 2005 payment rate is adjusted to reflect a 50/50 blend of CY 2004 product-specific median costs and the CY 2005 simulated median.

CMS Proposal: *". . . for CY 2006, we are proposing to establish payment rates for blood and blood products under the OPPS by using the same simulation methodology described in the November 15, 2004 final rule with comment period (69 FR 65816). For blood and blood products whose 2006 medians would have otherwise experienced a decrease of more than 10 percent in comparison with their CY 2005 payment rates, we are proposing to adjust the simulated medians by limiting their decrease to 10 percent."*

CMS Final Rule: *". . . for the CY 2006 OPPS, the final median costs for blood and blood products are set at the greater of: (1) the simulated median costs calculated from the CY 2004 claims data; or (2) 95 percent of the CY 2005 adjusted median costs for these products."*

In summary, CMS has modified its proposal to limit payment decreases for blood and blood products to 5% of 2005 median costs rather than 10% as proposed. By limiting blood product decreases from 2005 to 2006, overall, payments will increase by an average of 5.8%. Compared to the October quarterly update, 15 of 34 payment rates for blood and blood products decrease in 2006 to a maximum of minus 2.3%.

Observation Services Payment

(*Federal Register* pages 68688 - 68695)

Background: Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether a patient will require further inpatient treatment or if he or she should be discharged from the hospital. In CY 2002, CMS established a separate OPPS payment APC for observation services for three medical conditions: chest pain, congestive heart failure, and asthma. A number of accompanying requirements were also established.

Recently, CMS received comments and recommendations by the APC Panel regarding the continuing

administrative burden on hospitals when attempting to differentiate between packaged and separately payable observation services for purposes of billing observation correctly.

CMS Proposal: *". . . we are proposing two changes in payment policy for observation services in CY 2006. First, we are proposing to discontinue HCPCS codes G0244 (Observation care by facility to patient), G0263 (Direct admission with CHF, CP, asthma), and G0264 (Assessment other than CHF, CP, asthma) and to create two new HCPCS codes to be used by hospitals to report all observation services whether separately payable or packaged, and direct admission for observation care:*

- GXXXX—Hospital observation services, per hour
- GYYYY—Direct admission of patient for hospital observation care

Second, we are proposing to shift determination of whether or not observation services are separately payable under APC 0339 from the hospital billing department to the OPPS claims processing logic. That is, hospitals would bill GXXXX when observation services are provided to any patient admitted to ''observation status,'' regardless of the patient's status as an inpatient or outpatient. Hospitals would additionally bill GYYYY when observation services are the result of a direct admission to ''observation status'' without an associated emergency room visit, hospital outpatient clinic visit, or critical care service on the day of or day before the observation services. Both of these new HCPCS codes would be assigned a new status indicator that would trigger OCE logic during the processing of the claim to determine if the observation service is packaged with the other separately payable hospital services provided or if a separate APC payment for observation services is appropriate. . . . We will expect hospitals to utilize GXXXX to accurately report all observation services provided to beneficiaries, whether the observation would be packaged or separately payable, to assist us in developing consistent and complete hospital claims data regarding the utilization and costs of observation services. The units of service reported with GXXXX would equal the number of hours the patient is in observation status."

CMS Final Rule: CMS has adopted the above proposal as final. As proposed and discussed above, CMS has created two new G-codes for reporting observation services and direct admission to observation.
- G0378 – Hospital observation services, per hour (cited in the proposed rule as ''GXXXX'').
- G0379 – Direct admission of patient for hospital observation care (cited in the proposed rule as ''GYYYY'').

In CY 2006, CMS will continue to use the same criteria used in CY 2005 to determine whether a hospital should receive separate OPPS payment for medically necessary observation care provided to a patient with congestive heart failure, chest pain, or asthma. For a complete listing of the requirements, including a listing of the International Classification of Disease, Ninth Edition, Clinical Modification (ICD-9-CM) codes eligible for billing observations services (please note, these codes remain unchanged from prior years), please click on the *Federal Register* text link at the beginning of this section.

CMS will continue its policy of paying for a Level I Clinic Visit when a Medicare beneficiary is directly admitted into a hospital outpatient department for observation care that does not qualify for separate observation payment.

Inpatient-Only Procedures Payment

(*Federal Register* pages 68695 - 68699)

Background: CMS identifies procedures that are typically provided only in an inpatient setting, and therefore, would not be paid by Medicare under the OPPS. These procedures comprise what is referred to as the "inpatient list." The inpatient list specifies those services that will only be paid when provided in an inpatient setting because of the nature of the procedure and the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged. These procedures are assigned a status code of "C" and hospitals are advised to admit beneficiaries requiring these procedures to receive payment. Each year CMS, with input from the APC Panel, reviews the inpatient list using specific criteria to determine whether any procedures should be moved from the inpatient list and assigned to an APC.

CMS Proposal: *". . . for CY 2006, we are proposing to remove 25 procedures from the inpatient list and to assign 23 of these procedures to clinically appropriate APC . . . . We are not proposing to assign two of these procedures to APC groups, that is, CPT codes 00634 (Anesthesia for procedures in lumbar region; chemonucleoysis) and 01190 (Anesthesia for obturator neurectomy; intrapelvic) because they are anesthesia procedures for which a separate payment is not made under the OPPS. Payment for these two procedures would be packaged into the procedures with which they are billed."*

CMS Final Rule: CMS has adopted the above proposal as final. In addition, responding to comments, CMS has included one additional procedure to be removed from the inpatient only list. For CY 2006, 26 procedures will be removed from the inpatient list. 24 of these procedures will be assigned to clinically appropriate APCs, while two others will be packaged as discussed above.

Payment for Ancillary Outpatient Services When Patient Expires

(*Federal Register* pages 68700 - 68701)

Background: In CY 2003, CMS implemented a new HCPCS modifier -CA to address situations where a procedure on the OPPS inpatient list must be performed to resuscitate or stabilize a patient (whose status is that of an outpatient) with an emergent, life-threatening condition, and the patient dies before being admitted as an inpatient. In CY 2004, CMS created APC 0375 to reimburse services provided on the same date billed for a procedure with modifier -CA. The payment for APC 0375 was set at $1,150, which was the amount for APC 1513: New Technology—Level XIII. For CY 2005, CMS used claims data for this APC and used the standard APC methodology to determine a payment rate of $3,217.47.

CMS Proposal: "*We are proposing to continue to make one payment under APC 0375 for the services that meet the specific conditions discussed in previous rules for using modifier -CA, based on calculation of the relative payment weight for APC 0375, using charge data from CY 2004 claims for line items with a HCPCS code and status indicator ''V,'' ''S,'' ''T,'' ''X,'' ''N,'' ''K,'' ''G,'' and ''H,'' in addition to charges for revenue codes without a HCPCS code. In accordance with this methodology, for CY 2006, we calculated a median cost of $2,528.61 for APC 0375."*

CMS Final Rule: CMS has adopted the above proposal as final. The payment rate for APC 0375 is set at $2,719.74 for 2006.

CMS states that the volume of hospital claims billed with the -CA modifier increased from 18 in CY 2003 to 300 in CY 2004. Although CMS acknowledges that the modifier -CA was introduced recently and is subject to a learning curve, CMS is concerned that some procedures reported by hospitals with the -CA modifier in CY 2004 may not have been provided appropriately (to patients with emergent, life-threatening conditions, where the inpatient procedure was performed on an emergency basis to resuscitate or stabilize the patient). CMS will continue to monitor hospital use of this modifier to assess whether a future proposal to change the policies regarding payment for APC 0375 would be warranted or whether hospitals simply require further education regarding the correct use of the modifier -CA. CMS' billing and payment rules for using the -CA modifier are available on the CMS Web site at: http://www.cms.hhs.gov/manuals/pm_trans/A02129.pdf.

Physician Oversight of Mid-Level Practitioners in Critical Access Hospitals

(*Federal Register* pages 68712 - 68713)

Background: In the CAH setting, physician oversight is required for services provided by nonphysician practitioners such as physician assistants (PAs), nurse practitioners (NPs), and clinical nurse specialists (CNSs). Currently, CAHs with a high volume of outpatients need to have a physician review and sign a random sample of 25% of outpatient medical records.

Nonphysician practitioners have brought their concerns to the attention of CMS with regard to their ability to

practice under their own state laws. Particularly, the nonphysician practitioners believe the current CMS regulations and guidelines impede their ability to practice in CAHs. Certified nurse midwives, NPs, and CNSs disagree with the need for a physician to review records of patients that have been in their care when state law permits them to practice independently. Furthermore, in its June 2002 Report to Congress, available at: http://www.medpac.gov/publications/congressional_reports/jun02_NonPhysCoverage.pdf, MedPAC reported that several studies have shown comparable patient outcomes for the services provided by physician and nonphysician practitioners. CMS, however, remains concerned that it has a responsibility to continue to ensure the safety and quality of services provided to Medicare beneficiaries in states without independent practice laws.

CMS Proposal: *". . . we are proposing to revise the regulation at § 485.631(b)(iv) to defer to State law regarding the review of records for outpatients cared for by nonphysician practitioners. We are proposing that if State law allows these practitioners to practice independently, we would not require physicians to review and sign medical records of outpatients cared for by nonphysician practitioners. However, for those States that do not allow independent practice of nonphysician practitioners, we would continue to maintain that periodic review is performed by the physician on outpatient records under the care of a nonphysician practitioner. In addition, we would allow the CAH to determine the sample size of the reviewed records in accordance with current standards of practice to allow the CAH flexibility in adapting the review to its particular circumstances. Specifically, we are proposing that the physician periodically (that is, at least once every 2 weeks) reviews and signs a sample of the outpatient records of nonphysician practitioners according to the facility policy and current standards of practice. We would still require periodic review and oversight of all inpatient records by physicians."*

CMS Final Rule: Based on comments, and to provide clarity, CMS has revised the above proposal slightly, essentially deferring control and oversight of nonphysician practitioner to state laws.

". . . where State law requires record reviews or co-signatures, or both, by a collaborating physician, physicians must periodically, but not less than every 2 weeks, review and sign a sample of outpatient records of patients who were cared for by nonphysician practitioners in accordance with the policies of the CAH and current standards of practice. In addition, where State law does not require record reviews or co-signatures, or both, by a collaborating physician, physician are not required to review and sign outpatient records of patients who were cared for by nonphysician practitioners."

MedPAC Recommendations

(*Federal Register* pages 68711 - 68712)

MedPAC is an independent federal body established by the BBA to advise the U.S. Congress on issues affecting the Medicare program. MedPAC submits reports to Congress in March and June that summarize Medicare payment policy recommendations.

The March 2005 report, available on the MedPAC Web site at: http://www.medpac.gov/publications/congressional_reports/Mar05_EntireReport.pdf included the following two recommendations relating specifically to the OPPS:

- Recommendation 1: Congress should increase payment rates for the OPPS by the projected hospital marketbasket index less 0.4% for CY 2006. CMS has provided a full marketbasket update for 2006 and a complete discussion regarding the update to the conversion factor is provided in the "Conversion Factor" section above.

- Recommendation 2: Congress should extend "hold harmless" payments under the OPPS for rural SCHs and other rural hospitals with 100 or fewer beds through CY 2006. By law, the transitional corridor payments for rural hospitals are set to expire on December 31, 2005. A complete discussion of transitional corridor payments is provided in the "Transitional Corridor Payments" section above.

The June 2005 report, available on the MedPAC Web site at:
http://www.medpac.gov/publications/congressional_reports/June05_Entire_report.pdf included recommendations related to pharmacy overhead payments in the hospital outpatient department. A complete discussion of pharmacy overhead can be found in the "Additional Payment for Drugs and Biologicals to Account for Pharmacy Overhead Costs" section above.