SUMMARY OF THE FINAL CALENDAR YEAR 2007 MEDICARE HOSPITAL OUTPATIENT RULE

November 2006

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I. OVERVIEW

CMS published the final Medicare Outpatient Prospective Payment System (OPPS) rule for calendar year (CY) 2007 in the November 2 display version of the *Federal Register*. Changes are effective January 1, 2007 unless otherwise noted. This document provides an overview of the final rule. Additional information regarding the OPPS is available on the CMS Web site at http://www.cms.hhs.gov/HospitalOutpatientPPS/.

Each section of this summary indicates its location in the *Federal Register*. Text in italics is extracted from the *Federal Register*.

II. Reporting of Hospital Quality Data and Other Quality Initiatives

Reporting Requirements to Receive the Full Marketbasket Update

(*Federal Register* pages 848 – 882)

Background: Currently, there is no requirement for hospitals paid under the OPPS to report quality data to CMS. In contrast, under the Inpatient Prospective Payment System (IPPS), the annual payment update is linked to the collection of quality measures as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and the Deficit Reduction Act of 2005 (DRA). Under the IPPS, CMS created the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program. Hospitals that do not comply with the program requirements receive a reduction to the IPPS annual payment update.

CMS stated in the proposed rule that statute permits the Secretary to *". . . establish, in a budget neutral manner, . . . adjustments as determined to be necessary to ensure equitable payments"* under the OPPS. CMS considers the absence of OPPS quality measures an issue of payment equity.

CMS Proposal: *"We are proposing to employ our equitable adjustment authority under section 1833(t)(2)(E) of the Act to adapt the quality improvement mechanism provided by the IPPS RHQDAPU program for use in the OPPS."*

". . . we would initially implement an OPPS RHQDAPU program by reducing the OPPS conversion factor update in CY 2007 for those hospitals that are required to report quality data under the IPPS RHQDAPU program in order to receive the FY 2007 update, and fail to meet the requirements for receiving the full FY 2007 IPPS payment update. These hospitals would receive an update to the CY 2007 OPPS conversion factor that is reduced by 2.0 percentage points."

CMS Final Rule: *". . . we are delaying implementation of the OPPS RHQDAPU program until CY 2009, when we will implement a 2.0 point reduction to the OPPS conversion factor update for those hospitals that do not meet the specific requirements of the CY 2009 OPPS RHQDAPU program. The CY 2009 program will be based upon CY 2008 hospital reporting of effective measures of the quality of hospital outpatient care that have been carefully developed and evaluated, and endorsed as appropriate, with significant input from stakeholders."*

CMS is delaying implementation of the OPPS RHQDAPU program until CY 2009, concluding that the OPPS quality update reporting program should be based on measures specifically for hospital outpatient care.

CMS states in the final rule that it plans to work quickly and collaboratively with the hospital community to develop and implement quality measures specific to hospital outpatient services. CMS believes that this process will require two years and the CY 2009 quality reporting program will be based upon CY 2008 hospital reporting.

Unlike the IPPS quality reporting program, which was required by law, the development of the OPPS quality reporting program is a CMS initiative. CMS states in the final rule that it continues to believe that statute permits creation of this program under their "equitable adjustment authority."

Health Care Information Transparency and Health Information Technology

(*Federal Register* pages 882 – 896)

The proposed rule sought comment on transparency initiatives and the use of health information technology (HIT) as a means to help improve health care quality and efficiency. Although there were no specific proposals related to these two topic areas, CMS has been fostering discussion around these topics over the past year. The final rule addresses CMS' current efforts and the comments received on both of these issues.

A complete discussion of this topic area can be found in the *Federal Register* pages referenced in the heading above.

III. Ambulatory Payment Classification (APC) Payments

Conversion Factor

(*Federal Register* pages 153 – 154)

Background: Outpatient payment rates are determined by multiplying the relative weight for an APC by the conversion factor. The current, 2006 conversion factor is $59.511.

CMS Proposal: *"The proposed marketbasket increase update factor of 3.4 percent for CY 2007, the required wage index budget neutrality adjustment of approximately 0.999908021, the return of 0.04 percent for the difference in the pass-through set-aside, and the proposed adjustment for the rural payment adjustment for rural SCHs, including rural EACHs, of 0.999883468 result in a proposed conversion factor for CY 2007 of $61.551."*

CMS Final Rule: *"The marketbasket increase update factor of 3.4 percent for CY 2007, the required wage index budget neutrality adjustment of approximately 0.999331979, the adjustment of 0.04 percent for the difference in the pass-through set-aside, and the adjustment for the rural payment adjustment for rural SCHs, including rural EACHs, of 0.999975941 result in a standard conversion factor for CY 2007 of $61.468."*

Wage Index Adjustment

(*Federal Register* pages 154 – 164)

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 IPPS to the OPPS conversion factor. These wage indexes also apply to Tax Equity Fiscal Responsibility Act of 1982 (TEFRA) hospitals that participate in OPPS, but not in the IPPS.

CMS Proposal: *". . . in accordance with our established policy, we are proposing to use the FY 2007 final version of these wage indices to determine the wage adjustments for the OPPS payment rate and copayment standardized amount that we will publish in our final rule for CY 2007."*

CMS Final Rule: CMS has adopted the above proposal as final with no revisions and will use the finalized IPPS wage indexes published in the October 11, 2006 *Federal Register* for the CY 2007 OPPS. In adopting the final federal fiscal year (FFY) 2007 IPPS 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 MMA; and

- a 100% application of the occupational mix adjustment to the average hourly wage used to calculate the wage index.

Rural Hospital Adjustment

(*Federal Register* pages 171 – 174)

Background: The MMA required CMS to conduct a study to determine if the cost of providing outpatient care in rural hospitals exceeds the cost in urban hospitals. CMS' analysis found that all rural hospitals give some indication of having higher cost per unit, but that rural Sole Community Hospitals (SCHs) demonstrated significantly higher cost per unit than urban hospitals. For CY 2006, CMS provided a 7.1% add-on to the OPPS payment rate for rural SCHs.

CMS Proposal: *"For CY 2007, we are proposing to continue our current policy of a budget neutral 7.1 percent payment increase for rural SCHs . . . for all services and procedures paid under the OPPS, excluding drugs, biologicals, brachytherapy seeds, and services paid under pass-through payment policy specified services."*

CMS Final Rule: CMS has adopted the above proposal as final with no revisions. CMS stated in both the proposed and final rules that it will not re-establish the adjustment amount on an annual basis, but might review the adjustment in the future and, if appropriate, revise it. In addition, CMS clarifies that Essential Access Community Hospitals (EACHs) are eligible to receive the add-on.

Transitional Corridor Payments

(*Federal Register* pages 169 – 171)

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 SCHs located in rural areas. Cancer hospitals and children's hospitals are permanently held harmless from the impact of the OPPS.

CMS Proposal: *"Section 5105 of Pub. L. 109–171 reinstituted the hold harmless transitional outpatient payments (TOPs) for covered OPD services furnished on or after January 1, 2006, and before January 1, 2009, for rural hospitals having 100 or fewer beds that are not SCHs. When the OPPS payment is less than the payment the provider would have received under the previous reasonable cost-based system, the amount of payment is increased by 95 percent of the amount of the difference between those two payment systems for CY 2006, by 90 percent of the amount of that difference for CY 2007, and by 85 percent of the amount of that difference for CY 2008."*

CMS Final Rule: As stated in the proposed rule, CMS will continue to phase out transitional corridor payments through CY 2008 as required by the DRA. For CY 2007, when the OPPS payment is less than the payment the provider would have received under the previous reasonable cost-based system, the amount of payment is increased by 90% of the amount of the difference between those two payment systems.

Cost Outliers

(*Federal Register* pages 174 – 183)

Background: Outlier payments are made for individual services or procedures with extraordinarily high costs compared to the payment rates for their APC group. For CY 2006, the outlier threshold is met 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 $1,250 fixed-dollar threshold. The dual test is intended to eliminate outlier payments for low-cost services and provide higher outlier payments for more expensive procedures. For CY 2006, CMS reduced the target for aggregate outlier payments from 2.0% of total OPPS payments to 1.0%.

CMS Proposal: *"For CY 2007, we are proposing to continue our policy of setting aside 1.0 percent of aggregate total payments under the OPPS for outlier payments . . . In order to ensure that estimated CY 2007 aggregate outlier payments would equal 1.0 percent of estimated aggregate total payments under the OPPS, we are proposing that the outlier threshold be set 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 $1,825 fixed-dollar threshold."*

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

The fixed-dollar threshold increase is due mainly to CMS' revised methodology used in calculating the overall cost-to-charge ratio (see below). 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.

Revision to the Overall Cost-to-Charge (CCR) Calculation

(*Federal Register* pages 71 – 78)

Background: CMS uses the overall CCR to identify the outlier threshold, to model payments for services that are paid at charges reduced to cost, and, during implementation, to determine outlier payments and payments for other services. Additionally, CMS uses the overall CCR to estimate costs using charges on a claim when there is no accurate cost center CCR. CMS has discovered that the Fiscal Intermediaries (FIs) are using a different calculation of the overall CCR for payment calculations than CMS uses to model the OPPS. CMS stated that the FI calculation, on average, result in higher overall CCRs than CMS' calculation.

CMS Proposal: *"We believe that a single overall CCR calculation should be used for all components of the OPPS for both modeling and payment. Therefore, we are proposing to use the modified overall CCR calculation . . . when the hospital-specific overall CCR is used for any of the following calculations—in the CMS calculation of median costs for OPPS ratesetting, in the CMS calculation of the outlier threshold, in the*

fiscal intermediary calculation of outlier payments, in the CMS calculation of statewide CCRs, in the fiscal intermediary calculation of pass-through payments for devices, and for any other fiscal intermediary payment calculation in which the current hospital-specific overall CCR may be used now or in the future."

CMS Final Rule: CMS has adopted the above proposal as final with no revisions. The revised calculation incorporates weighting by Medicare Part B charges, but excludes allied health costs for modeling and payment. A complete discussion of the revised calculation can be found on the *Federal Register* pages referenced in the heading above.

Default Cost-to-Charge Ratios

(*Federal Register* pages 164 – 169)

Background: CMS uses CCRs to determine outlier payments, payments for pass-through devices, and monthly interim transitional corridor payments under the OPPS. Default CCRs are used for hospitals that are determined to have invalid CCRs, such as new hospitals, hospitals with a CCR that falls outside predetermined floor and ceiling thresholds, or hospitals that have recently given up their all-inclusive rate status. Current OPPS policy also requires hospitals that experience a change of ownership, but that do not accept assignment of the previous hospital's provider agreement, to use the previous provider's CCR.

CMS Proposal: *"For CY 2007, we are proposing to apply this treatment of using the default statewide CCR to include an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with 42 CFR 489.18, and that has not yet submitted its first Medicare cost report. We are proposing that this policy be effective for hospitals experiencing a change of ownership on or after January 1, 2007."*

"We believe that a hospital that has not accepted assignment of an existing hospital's provider agreement is similar to a new hospital that will establish its own costs and charges. We believe that the hospital that has chosen not to accept assignment may have different costs and charges than the existing hospital. Furthermore, we believe that the hospital should be provided time to establish its own costs and charges. Therefore, we are proposing to use the default statewide CCR to determine cost-based payments until the hospital has submitted its first Medicare cost report."

CMS Final Rule: CMS has adopted the above proposal as final with no revisions. The default CCRs, both rural and urban, are available for the nation on the *Federal Register* pages referenced in the heading above.

Recalibration of APC Weights

(*Federal Register* pages 48 – 132)

Background: CMS is required to review and revise the APC relative payment weights at least annually. CMS calculated the APC weights for 2006 using claims for services furnished on or after January 1, 2004 and before January 1, 2005.

CMS Proposal: *"We are proposing that the APC relative weights for CY 2007 continue to be based on the median hospital costs for services in the APC groups. For the CY 2007 OPPS final rule, we are proposing to base APC median costs on claims for services furnished in CY 2005 and processed before June 30, 2006."*

CMS Final Rule: CMS has adopted the above proposal as final with no revisions. In addition, CMS used the most recently submitted cost report data as reported to the Healthcare Cost Report Information System (HCRIS) as of June 30, 2006, to calculate the CCRs used to reduce the billed charges to costs for purposes of calculating the median costs on which the CY 2007 OPPS rates are based.

A complete discussion of the recalibration of APC weights for CY 2007 can be found on the *Federal Register* pages referenced in the heading above. The final APC relative weights and payments, which are based on CY 2005 claims that were processed before January 1, 2006, can be found in Addenda A and B posted on the CMS Web site at http://www.cms.hhs.gov/HospitalOutpatientPPS/HORD/list.asp - TopOfPage.

IV. Transitional Pass-Through Payments

Pass-Through Spending

(*Federal Register* pages 523 – 528)

Background: The Balanced Budget Refinement Act of 1999 (BBRA) provided transitional pass-through payments for certain drugs, pharmaceuticals, biologicals, and medical devices. For CY 2007, CMS estimates that total pass-through spending for device categories receiving pass-through payment in CY 2006 that will continue payment during CY 2007, and new device categories that may become eligible during CY 2007 will amount to 0.21% of total OPPS payments. Pass-through spending for drugs and biologicals with pass-through status in CY 2007 equals zero. The cap on the total amount of pass-through spending is 2.0% of total OPPS payments.

CMS Proposal: *"Because we estimate pass-through spending in CY 2007 will not amount to 2.0 percent of total projected OPPS CY 2007 spending, we are proposing to return 1.87 percent of the pass-through pool to adjust the conversion factor . . ."*

CMS Final Rule: *"Because we estimate that pass-through spending in CY 2007 will not amount to 2.0 percent of total projected OPPS CY 2007 spending, we will return 1.79 percent of the pass-through pool to adjust the conversion factor . . ."*

Payment for Pass-Through Drugs, Biologicals, and Radiopharmaceuticals

(*Federal Register* pages 444 – 452)

Background: The MMA requires pass-through drugs to be paid at the average sales price (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 2007 for nine drugs and biologicals."*

"Of these nine drugs and biologicals, . . . we are proposing to set payment for HCPCS codes J2503 and J9264 at the amounts determined under the competitive acquisition program, which will be a rate slightly different than the rate determined under the ASP methodology. Payment for all other drugs and biologicals would be equivalent to the payment these drugs and biologicals would receive in the physician office setting in CY 2007, where payment will be determined by the methodology described in § 419.904 and generally be equal to ASP+6 percent."

". . . in the absence of ASP data, we are continuing the policy we implemented during CYs 2005 and 2006 of using the wholesale acquisition cost (WAC) for the product to establish the initial payment rate. We note, however, that if the WAC is also unavailable, then we would make payment at 95 percent of the product's most recent AWP."

CMS Final Rule: CMS has adopted the above proposal as final. In addition, CMS has granted pass-through status in CY 2007 to an additional nine drugs and biologicals. A listing of the drugs and biologicals with pass-through status in CY 2007 is available on Table 23 (*Federal Register* page 452).

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 12 drugs whose pass-through status will expire on December 31, 2006. As described above, nine drugs that had pass-through status in CY 2006 will still be eligible for pass-through payments in CY 2007; an additional nine new drugs have been granted pass-through status for 2007. There has been no methodology change in payment for pass-through drugs from 2006.

Payment for Pass-Through Devices

(*Federal Register* pages 430 – 439)

Background: 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 Proposal: *". . . we have one effective device category for pass-through payment, C1820, which we created for pass-through payment effective January 1, 2006. We are proposing to continue to make payment under the pass-through provisions for category C1820 for CY 2007."*

"We are proposing that this category would expire from pass-through payment after December 31, 2007. This would provide the category transitional pass-through payment status for a 2-year period, in accordance with the statutory requirement that no category be paid as a pass-through device for less than 2 years, nor more than 3 years."

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

V. Payment for Drugs, Biologicals, and Radiopharmaceuticals Without Pass-Through Status

Payment for Drugs, Biologicals, and Radiopharmaceuticals—Packaging Criteria

(*Federal Register* pages 453 – 469)

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. The packaging threshold for establishing separate APCs for drugs and biologicals was set at $50 per administration during CYs 2005 and 2006. Because this packaging threshold will expire at the end of CY 2006, CMS evaluated four options for packaging levels in the proposed rule.

CMS Proposal: *". . . we considered and are proposing for CY 2007 and subsequent years is to update the packaging threshold for inflation using an inflation adjustment factor based on the Producer Price Index (PPI) . . ."*

"We are proposing that for each year beginning with CY 2007, we would adjust the packaging threshold by the PPI for prescription drugs, and the adjusted dollar amount would be rounded to the nearest $5 increment in order to determine the new threshold. The adjusted amount for CY 2007 was calculated to be $55.99, which we are rounding to $55. Therefore, for CY 2007, we are proposing to pay separately for drugs, biologicals, and radiopharmaceuticals whose per day cost exceeds $55 and packaging the costs of drugs, biologicals, and radiopharmaceuticals whose per day cost is less than or equal to $55 into the procedures with which they are billed."

CMS Final Rule: CMS has adopted the above proposal as final with no revisions. For CY 2007, CMS will pay for drugs over the $55 threshold at ASP + 6% unless deemed payable under an alternative methodology as indicated below.

Payment for Specified Covered Outpatient Drugs

(*Federal Register* pages 469 – 511)

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.

For CY 2006, the MMA required that payment for specified covered outpatient drugs 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. For CY 2006, CMS paid for the acquisition and overhead costs of separately paid drugs and biologicals at a combined rate of ASP + 6%.

CMS Proposal: *"Because pharmacy overhead costs are already built into the charges for drugs, biologicals, and radiopharmaceuticals, our current data therefore indicate that payment for drugs and biologicals and pharmacy overhead at a combined ASP+5 percent rate would serve as the best proxy for the combined acquisition and overhead costs of each of these products. Therefore, for CY 2007, we are proposing a policy of paying for the acquisition and overhead costs of separately paid drugs and biologicals at a combined rate of ASP+5 percent."*

CMS Final Rule: *". . . we are not finalizing our proposal to pay for drugs and biologicals at ASP+5 percent. Instead, after carefully considering all comments and the recommendations of the APC Panel, we are accepting the Panel's recommendation to continue to pay for separately payable drugs, biologicals and their associated pharmacy handling in the hospital outpatient department for CY 2007 at a combined rate of ASP+6 percent to maintain the stability of our payments. We believe that this rate will ensure suitable payment for the hospital pharmacy overhead costs associated with drugs and biologicals, while we continue to work with the hospital industry to understand the complex issues related to capturing and evaluating these overhead costs."*

Radiopharmaceuticals:
CMS does not have ASP data for radiopharmaceuticals and for CY 2007 CMS will extend the temporary policy of paying for radiopharmaceuticals at charges reduced to cost, using the overall hospital CCR.

CMS had proposed an alternative payment methodology for radiopharmaceuticals in the proposed rule, but based on comments, defaulted to the CY 2006 radiopharmaceutical payment methodology. CMS states in the final rule that payment for radiopharmaceuticals at cost provides hospitals with no incentive to supply radiopharmaceuticals in the most efficient manner and that CMS intends to develop a suitable prospective payment methodology for radiopharmaceutical products paid under the OPPS in future years, beginning in CY 2008.

Payment for New Drugs, Biologicals, and Radiopharmaceuticals With HCPCS Codes, but Without OPPS Hospital Claims Data

(*Federal Register* pages 511 – 523)

Background: For CYs 2005 and 2006, CMS paid separately for new drugs, biologicals, and radiopharmaceuticals that had Healthcare Common Procedure Coding System (HCPCS) codes, but did not have pass-through status. The payment rate was equivalent to the payment for the same items in the physician office setting (ASP + 6%).

CMS Proposal: *"For CY 2007, we are proposing to continue payment for these new drugs and biologicals with HCPCS codes as of January 1, 2007, but which do not have pass-through status, at a rate that is equivalent to the payment they would receive in the physician office setting, which would be established in accordance with the ASP methodology described in the CY 2006 Medicare Physician Fee Schedule final rule, where payment would generally be equal to ASP+6 percent."*

". . . in the absence of ASP data, we are continuing the policy we implemented during CYs 2005 and 2006 of using the wholesale acquisition cost (WAC) for the product to establish the initial payment rate. We note, however, that if the WAC is also unavailable, we would make payment at 95 percent of the product's most recent AWP."

"We are proposing to adopt this interim payment methodology in order to be consistent with how we pay for new drugs, biologicals, and radiopharmaceuticals without HCPCS codes, as discussed in the CY 2006 OPPS final rule with comment period (70 FR 68669). We further note that with respect to items for which we do not have ASP data, once their ASP data become available in later quarter submissions, their payment rates under OPPS will be adjusted so that the rates are based on the ASP methodology and set to ASP+6 percent."

CMS Final Rule: CMS has adopted the following payment rules as final for new drugs, biologicals, and radiopharmaceuticals with HCPCS codes, but without OPPS hospital claims data:

<u>Final Payment Policy for Drugs and Biologicals</u>:
". . . we are finalizing our policy for drugs and biologicals that have HCPCS codes but do not have pass-through status, and those that also do not have CY 2005 hospital claims data as follows: Packaging status will be determined using the threshold finalized in section V.B.2. of this final rule with comment period. That is, for CY 2007, items with a per administration cost of less than or equal to $55 would be packaged and items with an estimated per administration cost greater than $55 would receive separate payment."

"Estimating the per day costs for each item will be determined by multiplying the final payment rate (described in section V.B.3. of this final rule with comment period) for each product by the estimated average number of units typically furnished to a patient during one administration in the hospital outpatient setting as published in Table 27 of the proposed rule (71 FR 49595)."

"For those drugs and biologicals that have been classified as separately payable using this final methodology, payment will be determined using the methodology finalized in section V.B.3. of this final rule with comment period. Therefore, drugs that have been identified as separately payable in CY 2007 will be paid under the ASP-based methodology at a rate of ASP+6 percent, and will be subject to adjustments through the quarterly update process."

<u>Final Payment Policy for Radiopharmaceuticals</u>:
"For CY 2007, hospitals will receive payment for nonpass-through radiopharmaceuticals without hospital claims data that have been assigned HCPCS codes as of January 1, 2007, at the hospital's charge for the radiopharmaceutical adjusted to cost, using the hospital's overall cost-to-charge ratio. This methodology

will provide payment for nonpass-through radiopharmaceuticals using the same payment methodology that we have finalized for pass-through radiopharmaceuticals in CY 2007. . ."

VI. Hospital Coding and Payment for Visits

Clinic Visits, ED Visits, and Critical Care Services—Coding

(*Federal Register* pages 609 – 647)

Background: Currently, CMS instructs hospitals to use the CY 2006 CPT codes used by physicians to report clinic visits, emergency department (ED) visits, and critical care services on OPPS. However, CMS believes that CPT Evaluation and Management (E/M) codes were defined to reflect the activities of physicians and do not adequately describe the range and mix of services provided by hospitals during visits of clinic and ED patients and critical care encounters.

There are currently three levels of service in which emergency and clinic visits are paid: low, mid, and high. However, there is no national policy to determine the assignment of E/M codes (CMS is currently developing national guidelines). Hospitals are required to report facility resources for clinic and emergency department visits using CPT E/M codes and to develop internal hospital guidelines to determine what level of visit to report for each patient. While national guidelines are being developed, CMS has advised that each hospital's internal guidelines should follow the intent of the CPT code descriptors, in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the codes.

In the past, CMS has stated that it would not create new codes to replace existing CPT E/M codes for reporting hospital visits until national guidelines have been developed. However, although CMS does not yet have a formal set of guidelines appropriate to be applied nationally to report different levels of hospital clinic and emergency department visits and to report critical care services, CMS states that it has made significant progress in developing potential guidelines.

CMS Proposal: "*While we do not yet have a formal set of guidelines that we believe may be appropriately applied nationally to report different levels of hospital clinic and emergency department visits and to report critical care services, we have made significant progress in developing potential guidelines and, therefore, are proposing for CY 2007 the establishment of HCPCS codes to describe hospital clinic and emergency department visits and critical care services."*

Therefore, in the proposed rule CMS proposed the establishment of HCPCS codes to describe hospital clinic and emergency department visits and critical care services. Prior to implementation of national guidelines for the new hospital visit HCPCS codes, CMS proposed that hospitals continue to use their existing internal guidelines to determine the visit levels to be reported with these codes.

Clinic Visits:

CMS Final Rule: *"In response to the numerous comments related to creation of G-codes, we are postponing finalizing G-codes for clinic visits until national guidelines have been established, when we will again consider their possible utility."*

Emergency Department Visits:

CMS Final Rule: *"In response to the numerous public comments received, and as discussed in detail in section IX.B.1 of this preamble on clinic visit coding, we are postponing finalizing G-codes for Type A emergency department visits until national guidelines have been established, when we will again consider their possible utility."*

Background: CPT defines an emergency department as "*. . . an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day.*"

Under OPPS, hospitals must meet the CPT definition; if they do not, the ED codes should not be used. However, there are hospitals that maintain an ED, have obligations under the Emergency Medical Treatment and Labor Act (EMTALA), but do not operate a 24-hour ED (referred to as Type B EDs). Since Type B hospitals do not meet the CPT definition, they must bill clinic visit codes for services furnished, even though these hospitals believe that their resource costs are more similar to those of EDs than they are to Clinics. Currently, CMS has no way to determine the difference between resource costs for an ED that meets the CPT definition and operates a 24-hour ED (referred to as a Type A ED) and a Type B ED.

CMS Proposal: *". . . we proposed in the CY 2007 OPPS proposed rule (71 FR 49608) to establish a set of five G-codes for use by all entities that meet the definition of a DED under the EMTALA regulations in §489.24 but that are not Type A emergency departments . . . These codes are called "Type B emergency department visit codes."*

CMS Final Rule: *". . . we believe the creation of G-codes for Type B emergency departments is necessary because there currently are no CPT codes that fully describe this type of facility."*

"If we were to continue instructing Type B emergency departments to bill clinic visit codes, we would have no way to track resource costs for Type B emergency department visits as distinct from clinic visits. These new G-codes will serve as a vehicle to capture median cost and resource differences among visits provided by Type A emergency departments, Type B emergency departments, and clinics."

". . . we are adopting the G-codes in Table 37 for Type B emergency departments."

Table 37 (*Federal Register* pages 630 – 631) includes the finalized G-codes for Type B EDs effective beginning CY 2007.

Additionally, CMS is finalizing the definition of Type A EDs to distinguish them from Type B EDs:

"A Type A emergency department is a hospital-based facility or department that must be open 24 hours a day, 7 days a week and meet at least one of the following requirements:

(1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; or

(2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment."

". . . we believe that this definition of Type A emergency departments will neither narrow nor broaden the group of emergency departments or facilities that may bill the Type A emergency department visit codes in comparison to those that are currently correctly billing CPT emergency department visit E/M codes. Rather, we are refining and clarifying the definition for use in the hospital context."

<u>Critical Care Services</u>:
CMS Proposal: *"For critical care services, we proposed in the CY 2007 OPPS proposed rule (71 FR 49610) to create two new codes to replace hospitals' reporting of the CPT E/M critical care codes . . ."*

CMS Final Rule: *"For CY 2007, we are not adopting the proposed HCPCS G-codes in Table 39 for critical care services but we are adopting one new G-code (G0390) for trauma activation and response in*

association with critical care services. . . . because we see meaningful cost differences between critical care when billed with and without trauma activation, we will pay differentially for critical care when there is trauma activation associated with the critical care and when there is no trauma activation."

National Guidelines:
As stated above, there is currently no national policy to determine the assignment of E/M codes. In the final rule, CMS identifies the American Hospital Association (AHA)/American Health Information Management Association (AHIMA) guidelines as the most appropriate and well developed guidelines for use in the OPPS. However, CMS believes the AHA/AHIMA guidelines require short-term refinement before their full adoption by the OPPS, as well as continued refinement over time after their implementation.

CMS addressed eight general areas of concern regarding the AHA/AHIMA model. A complete discussion regarding these concerns is available in the *Federal Register* (*Federal Register* pages 661 – 682).

CMS will provide a minimum of 6-12 months notice to hospitals before implementing national guidelines, to provide sufficient time for providers to make the necessary systems changes and educate their staff.

Clinic Visits, ED Visits, and Critical Care Services—Payment

(*Federal Register* pages 647 – 682)

Background: Since the implementation of the OPPS, hospitals have been paid at three payment levels for both clinic and emergency department visits, even though hospitals have been reporting five resource-based coding levels of clinic and emergency department visits using CPT E/M codes. Critical care services have been paid at one level, with separate payment for the first 30 to 74 minutes of care and bundling of payment for all additional 30-minute increments of critical care services into payment for the first 30-74 minutes. If the critical care service is less than 30 minutes in duration, it is to be billed as either a clinic visit or an emergency department visit CPT code.

CMS Proposal: *". . . we proposed to create five payment levels for clinic and emergency department visits and one payment level for critical care services."*

"For CY 2007, we proposed to assign the five new Type A emergency department visit codes for services provided in a Type A emergency department to the five new Emergency Visit APCs, 0609, 0613, 0614, 0615, and 0616."

"For CY 2007, we proposed to assign the five new Type B emergency department visit codes for services provided in a Type B emergency department to the five new Clinic Visit APCs, 0604, 0605, 0606, 0607, and 0608. This payment policy for Type B emergency department visits is similar to our current policy which requires services furnished in emergency departments that have an EMTALA obligation but do not meet the CPT definition of emergency department to be reported using CPT clinic visit E/M codes, resulting in payments based upon clinic visit APCs."

CMS Final Rule: *"For CY 2007, we are finalizing without modification our proposal to create five payment levels for clinic and emergency department visits. We are finalizing with modification our proposal to create one payment level for critical care, by providing an additional payment when critical care is associated with trauma activation and response."*

". . . for CY 2007, we are finalizing our proposal to pay Type B emergency departments at clinic visit rates . . . We . . . continue to believe that it is appropriate to pay Type B emergency department visits at clinic visit rates, until we collect enough data to better determine their resource costs."

Table 42 (*Federal Register* pages 658 – 659) provides the final assignment of claims data from CY 2005 CPT E/M codes and other HCPCS codes to new visit APCs for CY 2007.

VII. APC Group Changes

(*Federal Register* pages 188 – 211)

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/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.

A complete discussion of APC group changes for can be found on the *Federal Register* pages referenced in the heading above.

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

APC Category	Status Indicator	2005	2006	2007
Clinic or Emergency Department Visit	V	6	6	10
Significant Procedures, Multiple Reduction Applies	T	208	208	213
Significant Procedures, No Multiple Reduction	S	123	128	144
Ancillary Services	X	44	46	45
Pass-Through Devices Categories	H	11	55	43
Non-Pass-Through Drugs/Biologicals, Brachytherapy Sources, and Blood and Blood Products	K	315	292	306
Partial Hospitalization	P	1	1	1
Observation	Q	0	1	0
New Technology	S/T	74	82	82
Total		**782**	**819**	**844**

New Technology APCs

(*Federal Register* pages 211 – 273)

Background: Since CY 2002, CMS retains services within New Technology APC groups until sufficient claims data are available to assign the service to a clinically appropriate APC. This policy allows CMS to move a service from a New Technology APC in less than two years if sufficient data are available or retain a service in a New Technology APC for more than three years if sufficient data are not available. Currently, new technologies are assigned to cost bands that range from:

- $0 to $50 in increments of $10;
- $50 to $100 in an increment of $50;
- $100 through $2,000 in intervals of $100; and
- $2,000 through $6,000 in intervals of $500.

These intervals are in two parallel sets of new technology APCs, one with status indicator "S" and the other with status indicator "T," allowing CMS to price New Technology services more appropriately and consistently.

CMS Proposal: *". . . there are 23 procedures currently assigned to New Technology APCs for which we believe . . . have data adequate to support their assignment to clinical APCs. For CY 2007, we are proposing to reassign these procedures to clinically appropriate APCs, applying their CY 2005 claims data to develop their clinical APC median costs on which payments would be based."*

CMS Final Rule: For CY 2007, CMS has adopted the above proposal to reassign 23 new technology procedures to clinically appropriate APCs. However, CMS has made some modifications to the final APC assignments for certain CPT codes. Table 10 (*Federal Register* page 273) describes these changes.

In addition, the final rule assigns these additional new technology services to clinically appropriate APCs for CY 2007:

- Nonmyocardial Positron Emission Tomography (PET) Scans (APC 0308);
- Stereotactic Radiosurgery (SRS) Treatment Delivery Services (APCs 0065, 0066, and 0067); and
- Magnetoencephalography (MEG) Services (APCs 0038 and 0209)

A complete discussion of new technology APCs including the APC reassignments for CY 2007 can be found on the *Federal Register* pages referenced in the heading above.

Device-Dependent APCs

(*Federal Register* pages 381 – 405)

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.

A complete description of the payment history for device-dependent APCs is available on the *Federal Register* pages referenced in the heading above.

CMS Proposal: *"For CY 2007, we are proposing to base the device-dependent APC medians on CY 2005 claims, the most current data available."*

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

In addition, CMS has implemented device to procedure code edits for specified devices and their associated procedures. This will help reduce incorrect billing errors for hospitals that fail to bill a procedure code with the reported device code.

Table 19 (*Federal Register* pages 404 – 405) includes edits that CMS will implement effective beginning CY 2007. CMS is accepting comments indefinitely, at outpatientpps@cms.hhs.gov, on device edits currently in place, or to assist in establishing appropriate edits going forward.

VIII. Drug Administration

Drug Administration—Coding

(*Federal Register* pages 579 – 589)

Background: In CY 2005, the OPPS transitioned to the use of CPT codes for drug administration services. These CPT codes allowed for more specific reporting of services, especially regarding the number of hours for an infusion, and provided consistency in coding between Medicare and other payers. For CY 2006, CMS implemented 20 of 33 drug administration CPT codes and created six new HCPCS C-codes that generally paralleled the CY 2005 CPT codes for the same services.

CMS Proposal: *"For the CY 2007 OPPS, we are proposing to continue the CY 2006 OPPS drug administration coding structure, which combines CPT codes with several C-codes."*

"In addition, because of the discrepancies between APC payments (based on per-visit hospital claims data) and per-service CPT/HCPCS coding, we provided special instructions to hospitals in CY 2005 and CY 2006 regarding modifier 59 in order to ensure proper OPPS payments, consistent with our claims processing logic. As we do not expect any changes to our coding structure for CY 2007 and because we have updated service-specific claims data from CY 2005, we no longer have the need for specific drug administration instructions regarding modifier 59. Instead, for CY 2007 we are proposing that hospitals apply modifier 59 to drug administration services using the same correct coding principles that they generally use for other OPPS services."

CMS Final Rule: *"After considering the recommendation of the APC Panel . . . and after carefully considering all the public comments received on the CY 2007 OPPS proposed rule, we have decided to adopt the full set of CPT codes for CY 2007 for use under OPPS. Therefore, we are accepting the August 2006 recommendation of the APC Panel to use only CPT codes for the reporting of drug administration services in the CY 2007 OPPS."*

Although the proposed rule sought no changes to the CY 2006 OPPS drug administration coding structure, which combines CPT codes with several C-codes, the final rule does change the drug administration coding structure, finalizing the use of only CPT codes for the reporting of drug administration services in CY 2007. Drug administration C-codes will no longer be reportable after December 31, 2006.

Table 32 (*Federal Register* page 587) shows the newly recognized drug administration CPT codes effective for CY 2007.

Drug Administration—Payment

(*Federal Register* pages 589 – 609)

Background: Through CY 2006, payment for additional hours of drug infusion has always been packaged, although separate codes for reporting these hours have been used under the OPPS since CY 2005. Hospitals began reporting more precise CPT codes in CY 2005 that included separate coding for the first hour of infusion versus additional hours of infusion. Therefore, CY 2007 is the first year that CMS has more detailed claims data for rate setting.

CMS Proposal: *"Upon review of the HCPCS median costs for all drug administration services, including injections and antigen therapy services, . . . we are proposing to assign HCPCS codes for CY 2007 to six new drug administration APCs . . . with payment rates based on median costs for the APCs from CY 2005 claims data . . ."*

CMS Final Rule: *"After carefully considering the public comments related to our proposed six-level APC structure for drug administration services, we are finalizing our proposal with modification to assign all CY 2007 HCPCS codes for drug administration services to six new drug administration APCs, as listed in Table 34, with payment rates based on median costs for the APCs as calculated from CY 2005 claims data."*

"We note that because our CY 2007 proposal reflected our assignment of CPT codes and C-codes to these APCs consistent with our drug administration coding proposal for CY 2007, we are finalizing our assignment of the newly recognized CPT codes to the APCs where their related C-codes were proposed for assignment."

Table 34 (*Federal Register* pages 605 – 606) shows the six-level APC structure for drug administration services.

IX. Other

Partial Hospitalization

(*Federal Register* pages 132 – 153)

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.

For CY 2006, CMS considered several alternatives to mitigate this drastic reduction in payment for PHP services, and finalized a policy to apply a 15% reduction to the combined hospital-based and CMHC median per-diem cost that was used to establish the CY 2005 PHP APC. CMS states that they adopted this reduction because it recognizes decreases in median per-diem costs in both the hospital data and the CMHC data, and also reduces the risk of any adverse impact on access to these services that might result from a large single-year rate reduction.

CMS Proposal: *"For CY 2007, we are proposing to calculate the CY 2007 PHP per diem payment rate using the same update methodology that we adopted in CY 2006. That is, we are proposing to apply an additional 15-percent reduction to the combined hospital-based and CMHC median per diem cost that was used to establish the CY 2006 per diem PHP payment."*

"To calculate the CY 2007 APC PHP per diem cost, we reduced $245.65 (the CY 2005 combined hospital-based and CMHC median per diem cost of $289 reduced by 15 percent) by 15 percent, which resulted in a combined median per diem cost of $208.80."

CMS Final Rule: *". . . for CY 2007, we are making a 5-percent reduction to the CY 2006 median per diem rate. This amount accounts for the downward direction of the data and addresses concerns about the magnitude of a 15-percent reduction in 1 year."*

" To calculate the CY 2007 APC PHP per diem cost, we reduced $245.65 (the CY 2005 combined hospital-based and CMHC median per diem cost of $289 reduced by 15 percent) by 5 percent, which resulted in a combined per diem cost of $233.37. If the PHP per diem cost continues to be low in CY 2008, we expect to continue the transition of decreasing the PHP median per diem cost to an amount that is reflective of the PHP data."

CMS establishes a separate outlier threshold for PHP payments to CMHCs at 3.40 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 528 – 579)

Background: The MMA required that beginning in CY 2004 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. 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. This provision is set to expire at the end of CY 2006.

CMS Proposal: *"We are proposing to pay separately for each of the sources listed in Table 29 below on a prospective basis for CY 2007, with payment rates to be determined using the CY 2005 claims-based median cost per source for each brachytherapy device."*

"Consistent with our policy regarding APC payments made on a prospective basis, we are proposing that the cost of brachytherapy sources be subject to the outlier provisions of section 1833(t)(5) of the Act. As indicated in section II.A.2. of the preamble to this proposed rule, for CY 2007, we are proposing a specific payment rate for brachytherapy sources, which will be subject to scaling for budget neutrality."

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

A complete discussion of brachytherapy source payment including GAOs study to determine appropriate payment amounts for devices of brachytherapy can be found on the *Federal Register* pages referenced in the heading above.

Blood and Blood Products Payment

(*Federal Register* pages 682 – 694)

Background: Separate payment is made for blood and blood products through APCs rather than packaging them into payments for the procedures with which they were administered. Since implementation of the OPPS, payment rates for blood and blood products has been scattered, first using external data, then using Medicare claims data and applying adjustments to the payment rates. A complete discussion of the payment background for blood and blood products is available on the *Federal Register* pages referenced above.

CMS Proposal: *"We are proposing to set the payment rates for blood and blood products for CY 2007 based on the unadjusted median costs for blood and blood products which are derived from the CY 2005 claims data . . . We believe that, in most cases, the unadjusted unit costs developed by this process are valid reflections of the estimated median costs of furnishing these specific blood products, and that no adjustment is required to result in appropriate payments for blood and blood products in CY 2007."*

CMS Final Rule: CMS has adopted the above proposal as final. However, CMS will provide a transitional payment for blood and blood products in CY 2007 by limiting the amount of the decrease from 2006 to 2007 to no more then 25%.

". . . for CY 2007 we are providing a payment transition for those blood products for which the difference between their CY 2006 adjusted median cost and their CY 2007 simulated median cost is greater than 25 percent. Specifically, we are setting the CY 2007 median costs upon which payments for blood and blood products are based at the higher of the CY 2007 unadjusted simulated median cost or 75 percent of the CY 2006 adjusted median cost on which the CY 2006 payment is based. This results in adjustment to the simulated median costs for CY 2007 for 7 of the 34 blood products."

A complete discussion of blood and blood product payment, including a table that describes the median costs for both 2006 and 2007 is available on the *Federal Register* pages referenced in the heading above.

Observation Services Payment

(*Federal Register* pages 695 – 703)

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. For CY 2006, CMS adopted two coding changes that affect how observation services are reported, making changes in the Outpatient Code Editor (OCE) to shift, from individual providers to the OPPS claims processing systems, the determination of whether or not observation services are separately payable or packaged.

Observation services reported using HCPCS code G0378 (Hospital Observation Services, Per Hour) that are eligible for separate payment map to APC 0339 (Observation). The CY 2006 payment rate for APC 0339 is $425.08. Direct admission to observation (G0379), when separately payable, is currently assigned for payment to APC 0600 (Low Level Clinic Visit) with a CY 2006 payment rate of $52.37.

These changes adopted for CY 2006 were intended to ensure more consistent hospital billing for observation services in order to guide our future analyses of payment for observation care and to simplify how observation services are reported and paid.

CMS Proposal: *". . . for CY 2007, we are proposing to continue applying the criteria for separate payment for observation services and the coding and payment methodology for observation services that were implemented in CY 2006, with one exception."*

"In section IX. of this preamble, we are proposing changes in coding and payment for clinic and emergency room visits. As part of these proposed changes, low level clinic visits would move from APC 0600 to APC 0604, with a CY 2007 proposed median cost of $49.93. Under the circumstances where direct admission to observation is separately payable, we are proposing to assign HCPCS code G0379 to APC 0604 consistent with its CY 2006 placement in the APC for Low Level Clinic Visits."

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

Inpatient-Only Procedures Payment

(*Federal Register* pages 703 – 715)

Background: CMS identifies procedures that are typically provided only in an inpatient setting, and therefore, should 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 only list using specific criteria to determine whether any procedures should be moved from the inpatient list and assigned to an APC.

CMS Proposal: *"The utilization data and clinical review findings for the eight procedures support our proposal to remove them from the inpatient list, and therefore, we are proposing to remove these procedures from the inpatient list and to assign them to clinically appropriate APC . . ."*

CMS Final Rule: CMS has adopted the above proposal as final. In addition, CMS is also accepting the APC Panel's recommendation regarding the removal of ten additional procedures from the inpatient list CMS is removing two other procedures based on public comment. Therefore, CMS is removing a total of 20 procedures from the inpatient list and assigning them to clinically appropriate APCs.

Table 46 (*Federal Register* pages 714 – 715) shows the 20 procedures removed from the inpatient list. The changes to the inpatient list will be effective for services furnished on or after January 1, 2007.

Payment for Ancillary Outpatient Services When Patient Expires

(*Federal Register* pages 715 – 719)

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 a status indicator of "C" and a modifier -CA. For CYs 2005 and 2006, CMS used claims data for this APC to apply the standard APC methodology to determine a payment rate. Since implementation, CMS attributes the large increases in hospital claims billed with modifier -CA due to the hospital's learning curve with respect to the modifier's appropriate use on claims. CMS expects that going forward into CY 2007, this modifier should represent more consistent reporting.

CMS Proposal: *"We do not propose any change to our policies regarding reporting of modifier -CA for CY 2007, or to our payment policy regarding APC 0375. Therefore, for CY 2007, we are proposing that hospitals continue reporting modifier –CA only under circumstances described in section VI. of Transmittal A-02-129, which provided specific billing guidance for the use of modifier –CA. In addition, 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 . . . "*

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

CMS states in the final CY 2007 final APC 0375 median cost is $3,549, significantly increased from the $2,717 median cost in CY 2006. According to CMS, this variation in median costs is expected because the specific cases that populate the claims data for APC 0375 likely exhibit only limited clinical and resource homogeneity among all the claims attributable to that APC in a given year and across different years for the same APC. Such cost variation for APC 0375 from year to year is generally anticipated and accepted because APC 0375 is unique in the OPPS and, by its definition, should always be limited in its use.

Critical Access Hospitals Emergency Medical Screening

(*Federal Register* pages 722 – 729)

Background: Currently, the Condition of Participation (CoP) for Critical Access Hospital (CAH) emergency services require that on-call doctors and non-physician practitioners report to the CAH's emergency room within 30 minutes (60 minutes if located in a frontier or remote area) to conduct an emergency medical screening. In the FFY 2005 IPPS final rule, CMS changed the regulatory requirements for emergency medical screening for acute care hospitals, allowing registered nurses to perform emergency medical screening on patients as long as it was within his or her scope of practice under state law. For this reason, there is less flexibility for CAH's emergency on-call personnel than for general hospitals.

CMS Proposal: *"We are proposing to . . . allow a CAH, if applicable, the flexibility of including a registered nurse, with training and experience in emergency care and who is on site at the CAH, as one of the qualified medical personnel available for emergency services, particularly emergency medical screenings, if the nature of the individual's request makes clear that the medical condition is not of an emergency nature and the individual's request for examination and treatment is within the registered nurse's scope of practice under State law."*

CMS Final Rule: CMS has adopted the above proposal as final. In addition, CMS is correcting an inadvertent inconsistency between the proposed rule preamble text and the proposed rule regulation text to indicate that the nature of a patient's request must be consistent with both applicable state laws **and** the CAH's bylaws or rules and regulations in order for a registered nurse to conduct a medical screening examination.

This rule aligns a CAH's CoP with that of acute care hospitals with regard to medical screening requirements. Under this final rule, if a registered nurse begins medical screening and determines that the patient's conditions are out of his or her scope of practice, then a physician, physician assistant, nurse practitioner, or a clinical nurse specialist must be contacted to see the patient within 30 or 60 minutes to conduct the emergency medical screening.

Ultrasound Screening for Abdominal Aortic Aneurysms

(*Federal Register* pages 720 – 722)

Background: Currently, ultrasound screenings for abdominal aortic aneurysms (AAAs) are not covered under Medicare. Therefore, there is no specific CPT code that describes an ultrasound screening for AAA. However, beginning January 1, 2007, services furnished under Part B for ultrasound screening for AAAs will be covered per enactment of the Deficit Reduction Act of 2005.

For a complete explanation of this coverage provision, providers should refer to the CY 2007 Medicare Physician Fee Schedule (PFS) final rule.

CMS Proposal: *". . . we are proposing to establish the following new HCPCS code, GXXXX (Ultrasound, B-scan and or real time with image documentation; for abdominal aortic aneurysm (AAA) screening) to be used to bill for the new service under both the Medicare Physician Fee Schedule and the OPPS. We are proposing to base the payment for GXXXX on equivalent hospital resources and intensity to those contained in CPT code 76775, which is assigned to APC 0266 (Level II Diagnostic and Screening Ultrasound) under the OPPS for CY 2007."*

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

CMS believes that the hospital costs associated with the screening are similar to those of the limited retroperitoneal ultrasound diagnostic examination and should be assigned to the same clinical APC for

reasons of clinical and resource homogeneity. Therefore, for CY 2007, CMS will assign G0389 to APC 0266.

Devices Replaced with No Cost or Hospital Receives Credit

(*Federal Register* pages 405 – 430)

Background: Through the years hospitals have received certain cardioverter-defibrillator (ICD) or pacemaker devices that may have contained malfunctions. In light of these malfunctions, manufacturers have offered either replacement devices at no cost to the hospital, credit for the device being replaced if a patient required a more expensive device, or a warranty package that would pay specified amounts for unreimbursed expenses to patients who had a replacement device implanted.

In the past, providers have been instructed not to charge for a device furnished to them without cost; however, currently, CMS has authorized hospitals to charge less than $1.01 in these situations. Moreover, this authorized charge was to ensure that the claim was not rejected by the Fiscal Intermediary Standard System (FISS), which will not accept claims unless there is a charge for each HCPCS code billed.

Furthermore, CMS wants to ensure that Medicare only pays for covered services and excludes the cost of the device, which the provider did not incur.

CMS Proposal: *". . . we are proposing, effective for services furnished on or after January 1, 2007, to reduce the APC payment and beneficiary copayment for selected APCs in cases in which an implanted device is replaced without cost to the hospital or with full credit for the removed device. The amount of the reduction to the APC payment rate would be calculated in the same manner as the offset amount that would be applied if the implanted device assigned to the APC had pass-through status as defined under § 419.66. The beneficiary's copayment amount would be calculated based on the reduced APC payment rate."*

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

If the APC to which the procedure code is assigned is one of the APCs listed in Table 20 (*Federal Register* page 429), the fiscal intermediary will reduce the unadjusted payment rate for the procedure by an amount equal to the percent in Table 20 times the unadjusted payment rate.

In addition, CMS is implementing the adjustment through the use of an appropriate modifier (modifier FB). Effective January 1, 2007, hospitals must append the modifier to the HCPCS code for the procedure in which the device was inserted on claims when the device that was replaced under warranty, recall or field action is one of the devices identified in Table 21 (*Federal Register* pages 429 – 430).