SUMMARY OF THE PROPOSED CALENDAR YEAR 2007 MEDICARE HOSPITAL OUTPATIENT RULE

September 2006

SUBMISSION OF COMMENTS

This document provides an overview of the Medicare proposed rule for the Outpatient Prospective Payment System (OPPS) for calendar year (CY) 2007. The Centers for Medicare and Medicaid Services (CMS) must receive comments on the proposal by 5 p.m. on October 10.

CMS requests that comments reference the file code CMS-1506-P and the specific "issue identifier" that precedes the section on which you choose to comment.

Comments can be submitted electronically at: http://www.cms.hhs.gov/eRulemaking (Attachments should be in Microsoft Word, WordPerfect, or Excel.)

Alternatively, one original and two copies can be delivered by:

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Department of Health and Human Services
Attention: CMS-1506-P
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I. OVERVIEW

CMS published the proposed Medicare Outpatient Prospective Payment System (OPPS) rule for calendar year (CY) 2007 in the August 23, 2006 *Federal Register*. Changes are effective January 1, 2006 unless otherwise noted. This document provides an overview of the proposed 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* and provides the "issue identifier" that CMS requests you reference in your comments.

Note: 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

Refer to "Hospital Quality Data" if you submit a comment on this issue.
(*Federal Register* pages 49665 – 49670)

Background: Currently, there is no requirement for hospitals paid under the OPPS to report quality data to CMS. Therefore, there is currently no link between quality of care and OPPS payments. In contrast, under the 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 states 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 is now considering the absence of OPPS measures to promote high quality care 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."

This proposal would require compliance with the IPPS RHQDAPU program to receive a full payment update in the outpatient setting for CY 2007. CMS believes that the quality measures reported for the FFY 2007 IPPS regarding inpatient hospital discharges reasonably represent the quality of care provided in the outpatient setting. CMS will accept this data as an interim step while quality measures specific to hospital outpatient care are being developed and refined.

To participate in the IPPS RHQDAPU program and receive a full marketbasket update for FFY 2007,

hospitals must follow a number of steps. These steps are available in detail on the "Reporting Hospital Quality Data for Annual Payment Update Reference Checklist" section of the QualityNet Exchange Web site at http://qnetexchange.org/public/. Additional information regarding the IPPS RHQDAPU program is available in the FFY 2007 IPPS final rule.

CMS notes that very few hospitals have failed to qualify for the full annual update under the IPPS RHQDAPU program and therefore, expect that the majority of hospitals will receive a full update under the OPPS. CMS will follow the determinations for FFY 2007 full IPPS payment update eligibility under the IPPS RHQDAPU program to determine eligibility for the full OPPS update. These determinations will be released on or about September 1, 2006.

Hospitals not subject to the IPPS RHQDAPU program will be exempt from the OPPS program. However, CMS plans to expand the OPPS RHQDAPU program in the coming years and will eventually require all hospitals that receive payment under the OPPS to participate in the program. This program is budget neutral.

CMS is seeking comments on their "equitable adjustment authority" and is seeking recommendations for other effective approaches to promote higher quality, more equitable care from stakeholders who believe that the proposed quality reporting initiative is not the most effective use of their authority.

CMS is also seeking comments on the development of hospital outpatient-specific quality and cost of care measures. Specifically, CMS is seeking comment on:

- Which current quality and cost of care measures, such as IPPS quality measures (especially the measure set as expanded under the DRA), physician practice measures, HCAHPS®/ACAHPS®, etc., are most applicable in the hospital outpatient setting?

- What would be the characteristics of an ideal measure set of quality and cost of care measures for the outpatient setting?

- What quality and cost of care measures are currently available for the outpatient setting?

- What privately led organizations or alliances are best suited to conduct needed development and consensus endorsement of outpatient quality measures?

Health Care Information Transparency and Health Information Technology

Refer to "Health Information Technology" or "Transparency of Health Care Information" if you submit a comment on this issue.
(*Federal Register* pages 49670 – 69671)

The proposed rule also addresses transparency initiatives and the use of health information technology (HIT) as a means to help improve health care quality and efficiency. This topic was thoroughly addressed in the April 25, 2006 IPPS proposed rule.

CMS is seeking comments on these issues.

III. Ambulatory Payment Classification (APC) Payments

Conversion Factor

Refer to "Conversion Factor" if you submit a comment on this issue.
(*Federal Register* page 49539)

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 market basket 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 (Essential Access Community Hospitals), of 0.999883468 result in a proposed conversion factor for CY 2007 of $61.551."*

Wage Index Adjustment

Refer to "OPPS: Wage Indices" if you submit a comment on this issue.
(*Federal Register* pages 49539 – 49541)

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."*

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.

The final FFY 2007 IPPS wage indexes to be used for the OPPS are expected to be published before October first.

Rural Hospital Adjustment

Refer to "OPPS: Rural SCH Payments" if you submit a comment on this issue.
(*Federal Register* page 49546)

Background: The MMA required CMS to conduct a study to determine if the cost of providing outpatient care in rural hospitals exceed 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 states in the proposed rule that they will not re-establish the adjustment amount on an annual basis, but might review the adjustment in the future and, if appropriate, revise the adjustment. In addition, CMS clarifies that Essential Access Community Hospitals (EACHs) are eligible to receive the add-on.

Transitional Corridor Payments

Refer to "OPPS: Rural Hospitals Hold Harmless Transitional Payments" if you submit a comment on this issue.
(*Federal Register* pages 49545 – 49546)

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: *"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."*

Cost Outliers

Refer to "Outlier Payments" if you submit a comment on this issue.
(*Federal Register* pages 49546 – 49547)

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."*

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

Refer to "APC Relative Weights" if you submit a comment on this issue.
(*Federal Register* pages 49528 – 49529)

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 they do not have an accurate cost center CCR. CMS has discovered that the calculation of the overall CCR that the fiscal intermediaries (FI) are using to determine outlier payments and payments for services paid at charges reduced to cost differs from the overall CCR that CMS uses to model the OPPS. CMS states that the FI calculation, on average, resulted 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 rate-setting, 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."*

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

Refer to "OPPS: Cost-to-Charge Ratios" if you submit a comment on this issue.
(*Federal Register* pages 49541 – 49545)

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."

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

Refer to "APC Relative Weights" if you submit a comment on this issue.
(*Federal Register* pages 49514 – 49548)

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."*

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 proposed 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

Refer to "OPPS: Estimated Transitional Pass-Through Spending" if you submit a comment on this issue.
(*Federal Register* pages 49595 – 49596)

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, there is only one device category receiving pass-through payment in CY 2006 that will continue payment during CY 2007, amounting to 0.13% 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 . . ."*

Payment for Pass-Through Drugs, Biologicals, and Radiopharmaceuticals

Refer to "Pass-Through Drugs" if you submit a comment on this issue.
(*Federal Register* pages 49580 – 49582)

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."

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 proposed rule identifies twelve drugs whose pass-through status will expire on December 31, 2006. Nine drugs that had pass-through status in CY 2006 will still be eligible for pass-through payments in CY 2007; no additional 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

Refer to "Pass-Through Devices" if you submit a comment on this issue.
(*Federal Register* page 49578)

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."

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

Payment for Drugs, Biologicals, and Radiopharmaceuticals—Packaging Criteria

Refer to "OPPS: Nonpass-Through Drugs, Biologicals, and Radiopharmaceuticals" if you submit a comment

on this issue.
(*Federal Register* pages 49582 – 49583)

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 to $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 is proposing to pay for drugs over the $55 threshold at ASP + 5% unless deemed payable under an alternative methodology as indicated below.

Payment for Specified Covered Outpatient Drugs

Refer to "OPPS: Non Pass-Through Drugs, Biologicals, and Radiopharmaceuticals" if you submit a comment on this issue.
(*Federal Register* pages 49584 – 49594)

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 is seeking comment on this proposal to pay for acquisition and overhead costs of drugs and biologicals

under the OPPS at ASP + 5% and the adequacy of the payment rates to account for actual acquisition and overhead costs incurred by hospitals for these items.

Radiopharmaceuticals:
CMS does not have ASP data for radiopharmaceuticals and has proposed to determine CY 2007 payment rates for separately payable radiopharmaceuticals using mean costs derived from the CY 2005 claims data, where the costs are determined using CMS' standard methodology of applying hospital-specific departmental CCRs to radiopharmaceutical charges, defaulting to hospital-specific overall CCRs only if appropriate departmental CCRs are unavailable. This proposal establishes the packaging threshold for radiopharmaceuticals at $55, as for other drugs under the CY 2007 OPPS.

CMS is seeking comment on the radiopharmaceutical payment methodology proposed for CY 2007. CMS is also seeking comment on the possibility of developing an alternative packaging threshold for radiopharmaceuticals to provide greater administrative simplicity for hospitals.

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

Refer to "Pass-Through Drugs" if you submit a comment on this issue.
(*Federal Register* pages 49594 – 49595)

Background: For CYs 2005 and 2006, CMS paid separately for new drugs, biologicals, and radiopharmaceuticals with Healthcare Common Procedure Coding System (HCPCS) codes, but which did not have pass-through status at a rate that was equivalent to the payment they received 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."

VI. Hospital Coding and Payment for Visits

Hospital Coding for E/M Services and Visits

Refer to "Visits" if you submit a comment on this issue.
(*Federal Register* pages 49604 – 49618)

Background: Currently, hospitals are instructed to use the current procedural terminology (CPT) codes used by physicians to report clinic and emergency department (ED) visits and critical care services on claims paid

under the OPPS. However, CMS realizes that the CPT Evaluation and Management (E/M) codes reflect the activities of physicians but do not 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, currently there is no national policy to determine the assignment of E/M codes. Therefore, in April 2000 hospitals were instructed to develop internal hospital guidelines to determine what level of visit should be reported for each patient. If hospitals followed this protocol they were considered in compliance with OPPS coding requirements. In the meantime, CMS continued to conduct a search for a national set of facility-specific codes and guidelines by evaluating several recommendations.

In conclusion, CMS, after several reviews, believes that the American Hospital Association (AHA) / American Health Information Management Association (AHIMA) guidelines are the most appropriate and well-developed guidelines for use in the OPPS. To that end, CMS is proposing to make modifications to the AHA/AHIMA guidelines in CY 2008.

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, CMS is proposing to create 17 new G-codes for CY 2007 to reflect hospital resource utilization for clinic and ED visits.

ED Visits:
"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 don't, the ED codes should not be used. However, there are many concerns regarding hospitals that maintain an ED and have obligations to 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 the services furnished, even though hospitals believe resource costs are more similar to those of EDs that meet the CPT definition than they are to the clinic costs. Currently, CMS has no way to distinguish the difference in resource costs between an ED that meets the CPT definition and operates a 24-hour ED (referred to as a Type A ED) versus a Type B ED.

Thus, CMS is proposing for CY 2007 to create ten new G-codes in order to evaluate the difference in resource costs used by a Type A ED and a Type B ED. The proposed Type A ED codes are more related to hospital resource use than the current five CPT E/M ED codes.

Critical Care Services:
Even though CMS proposed two new G-codes to replace the CPT E/M critical care codes, only one code is referenced in the table below with an associated APC. The reason being that proposed code Gccc2 will be assigned a status indicator "N" indicating that the code is packaged, as the predecessor code to Gccc2 was also packaged.

Therefore, the following table shows 16 of the 17 proposed G-codes and their associated APC assignments for CY 2007.

CPT/HCPCS Code for Reporting in CY 2007	Description	Proposed CY 2007 APC Title	Proposed CY 2007 APC	APC Status Indicator	Proposed CY 2007 APC Payment Rate
Gxxx1 Gzzz1 92012 G0101 G0245 G0248 G0249 G0264	Level 1 Hospital Clinic Visit Level 1 Hospital General ED Visit Eye Exam Established Patient CA Screen; Pelvic/Breast Exam Initial Foot Exam Pt Lops Demonstrate Use Home Inr Mon Provide Test Material, Equipment Assmt Otr CHF, CP, Asthma	Level 1 Hospital Clinic Visits	0604	V	$49.75
Gxxx2 Gzzz2 92002 92014 G0246 G0344	Level 2 Hospital Clinic Visit Level 2 Hospital General ED Visit Eye Exam, New Patient Eye Exam and Treatment Follow-up Eval of Foot Pt Lop Initial Preventive Exam	Level 2 Hospital Clinic Visits	0605	V	$61.90
Gxxx3 Gzzz3 92004	Level 3 hospital Clinic Visit Level 3 Hospital General ED Visit Eye Exam, New Patient	Level 3 Hospital Clinic Visits	0606	V	$83.38
Gxxx4 Gzzz4	Level 4 Hospital Clinic Visit Level 4 Hospital General ED Visit	Level 4 Hospital Clinic Visits	0607	V	$105.13
Gxxx5 Gzzz5 G0175	Level 5 Hospital Clinic Visit Level 5 Hospital General ED Visit OPPS Service, Sched Team Conf	Level 5 Hospital Clinic Visits	0608	V	$130.65
Gyyy1	Level 1 Hospital Special ED Visit	Level 1 Special Emergency Visits	0609	V	$51.23
Gyyy2	Level 2 Hospital Special ED Visit	Level 2 Special Emergency Visits	0613	V	$84.50
Gyyy3	Level 3 Hospital Special ED Visit	Level 3 Special Emergency Visits	0614	V	$133.52
Gyyy4	Level 4 Hospital Special ED Visit	Level 4 Special Emergency Visits	0615	V	$214.14
Gyyy5	Level 5 Hospital Special ED Visit	Level 5 Special Emergency Visits	0616	V	$330.98
Gccc1	Critical Care, First Hour	Critical Care	0617	S	$493.44

National Guidelines:

"Prior to our implementation of national guidelines for the new hospital visit HCPCS codes, we are proposing that hospitals may continue to use their existing internal guidelines to determine the visit levels to be reported with these codes . . . Because of our commitment to provide hospitals with 6-12 months notice prior to implementation of national guidelines, we expect that we will not implement national guidelines prior to CY 2008."

Therefore, as a step toward implementation of the national guidelines, CMS is proposing to modify the AHA/AHIMA guidelines. In doing so, CMS has addressed and is seeking comments on the following:

- increase the payment levels from three to five, to agree with the CY 2007 proposal for clinic and emergency visits;
- clarification of some interventions and/or provide additional examples to better assess the service that was given;
- inclusion of some separately payable services to be used as a proxy in determining visit levels;
- assignment of levels to various interventions, with the goal of differentiating five levels of services in a normal distribution, based on their respective hospital resources;

- feasibility of applying national guidelines to specialty clinic visits while ensuring appropriate OPPS payment for those services and suggestions for revisions to the guidelines models posted that could improve their utility in reporting such visits;

- violation of the Americans with Disabilities Act may be reported as an increased visit level, which increases a patient's copayment;

- differences in hospital clinic resource consumption for new patient visits, established patient visits, consultations; and

- creating guidelines for reporting visit levels in the Type B ED if implemented in the CY 2007 final rule.

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

VII. APC Group Changes

Refer to "OPPS: New HCPCS and CPT Codes" if you submit a comment on this issue.

The proposed 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 proposed 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 refer to the *Federal Register* pages 49548 – 49568.

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
Surgical Procedures	T	208	208	212
Significant Procedures	S	123	128	143
Ancillary Services	X	44	46	45
Pass-Through Devices, and Radiopharmaceutical Agents	H	11	55	1
Non-Pass-Through Drugs/Biologicals, Brachytherapy Sources, and Blood and Blood Products	K	315	292	337
Partial Hospitalization	P	1	1	1
Observation	Q	0	1	0
New Technology	S/T	74	82	82
Total		**782**	**819**	**831**

New Technology APCs

Refer to "New Technology APCs" if you submit a comment on this issue.
(*Federal Register* pages 49551 – 49556)

Background: Since CY 2002, CMS retains services within New Technology APC groups until sufficient claims data is 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."*

In addition, CMS is proposing to assign the following new technology services to clinically appropriate APCs:

- Nonmyocardial Positron Emission Tomography (PET) Scans;
- PET/Computed Tomography (CT) Scans;
- Stereotactic Radiosurgery (SRS) Treatment Delivery Services; and
- Magnetoencephalography (MEG) Services

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-Dependant APCs

Refer to "Device-Dependent APCs" if you submit a comment on this issue.
(*Federal Register* pages 49568– 49574)

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."*

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. CMS is seeking comments on the following list of devices that must be billed with associated procedure codes:

Device	Description	Device	Description
C1779	Lead, pmkr, transvenous VDD.	C1897	Lead, neurostim test kit.
C1785	Pmkr, dual, rate-resp.	C1898	Lead, pmkr, other than trans.
C1786	Pmkr, single, rate-resp.	C1899	Lead, pmkr/AICD combination
C1820	Generator, neuro rechg bat sys.	C1900	Lead, coronary venous.
C1882	AICD, other than sing/dual.	C2619	Pmkr, dual, non rate-resp.
C1895	Lead, AICD, endo dual coil.	C2620	Pmkr, single, non rate-resp.
C1896	Lead, AICD, non sing/dual.	C2621	Pmkr, other than sing/dual

To send comments on the above listing of devices, which must be billed with associated procedure codes, e-mail CMS at OutpatientPPS@cms.hhs.gov. Comments submitted on this issue to this e-mail address are not comments on this proposed rule and will not be mentioned in the CY 2007 OPPS final rule.

VIII. Drug Administration

Drug Administration – Coding

Refer to "OPPS: Drug Administration" if you submit a comment on this issue.
(*Federal Register* pages 49599 – 49604)

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 is seeking comments regarding hospitals' experiences in implementing, for purposes of reporting to other payers, the CY 2006 CPT codes that incorporate the concepts of initial, sequential, and concurrent drug administration services.

Drug Administration – Payment

Refer to "OPPS: Drug Administration" if you submit a comment on this issue.
(*Federal Register* pages 49599 – 49604)

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 . . ."*

Table 30-2 of the proposed rule describes the proposed 6-level drug administration APC structure, and is available on the *Federal Register* pages referenced in the heading above.

IX. Other

Partial Hospitalization

Refer to "Partial Hospitalization" if you submit a comment on this issue.
(*Federal Register* pages 49537 – 49539)

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 establishes a separate outlier threshold for PHP payments to CMHCs proposed 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

Refer to "OPPS: Brachytherapy" if you submit a comment on this issue.
(*Federal Register* pages 49596 – 49599)

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."

Table 29 of the proposed rule lists the separately payable brachytherapy sources for CY 2007, and can be found on the *Federal Register* pages referenced in the heading above.

Blood and Blood Products Payment

Refer to "Blood and Blood Products" if you submit a comment on this issue.
(*Federal Register* pages 49618 – 49620)

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."*

Observation Services Payment

Refer to "OPPS: Observation Services" if you submit a comment on this issue.
(*Federal Register* pages 49620 – 49621)

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 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."

Inpatient-Only Procedures Payment

Refer to "Inpatient Only Procedures" if you submit a comment on this issue.
(*Federal Register* pages 49621 – 49622)

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 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 . . ."*

A table that shows the eight procedures removed from the inpatient list is available on the *Federal Register* pages referenced in the heading above.

Payment for Ancillary Outpatient Services When Patient Expires

Refer to "Ancillary Outpatient Services" if you submit a comment on this issue.
(*Federal Register* pages 49622 – 49623)

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 is proposing a median cost of $3,539 for APC 0375 in CY 2007. This reflects an increase over the CY 2006 proposed rule median cost of $2,537.

Critical Access Hospitals Emergency Medical Screening

Refer to "CAHs: Emergency Medical Screening" if you submit a comment on this issue.
(*Federal Register* pages 49623 – 49624)

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."*

This proposal will align a CAH's CoP with that of acute care hospitals. Under this proposal, 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

Refer to "AAA Screening" if you submit a comment on this issue
(*Federal Register* page 49623)

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) proposed 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 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 is proposing to assign GXXXX to APC 0266 with a median cost of $98.59.

CMS will only respond to comments regarding payment for GXXXX under the OPPS in the CY 2007 OPPS final rule. All other responses regarding ultrasound screening for AAAs will be in the final rule implementing the Medicare PFS for CY 2007.

Devices Replaced with No Cost or Hospital Receives Credit

Refer to "Device-Dependent APCs" if you submit a comment on this issue.
(*Federal Register* pages 49574 – 49578)

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 replacement devices without 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), that 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."*

To avoid excessive program payments and beneficiary copayments for services being furnished if the device were provided without cost to the hospital, CMS is proposing to adjust specific APC payments if three criteria are met. In addition, CMS is proposing to implement the adjustment through the use of an appropriate modifier specific to a device replacement without cost or crediting of the cost of a device by the manufacturer. CMS realizes the proposed reporting requirements may be a burden to providers however, they believe they are unavoidable and necessary for correct payment.

A complete discussion of this topic is available on the *Federal Register* pages referenced in the heading above.