Analysis of Final Rule for 2007 Revisions to the Medicare Hospital Outpatient Prospective Payment System

The final rule for calendar year (CY) 2007 revisions to the Medicare Hospital Outpatient Prospective Payment System (OPPS) was published in the *Federal Register* on November 24, 2006. This rule becomes effective for services rendered on or after January 1, 2007.

This analysis will cover highlights of the revisions to the HOPPS that are considered to be of particular interest to HIM professionals. The listed page numbers refer to the beginning of the relevant section of the final rule published in the *Federal Register* and can be accessed at:
http://a257.g.akamaitech.net/7/257/2422/01jan20061800/edocket.access.gpo.gov/2006/pdf/06-9079.pdf

As always the final rule is extensive and covers various issues. Not all sections are included in this analysis.

Overview

On August 1, 2000 CMS began utilizing the OPPS as a direct result of the Balance Budget Act of 1997. The Balance Budget Act is part of an overall effort to control spending out of the Medicare Trust Fund. In 1999 the Balance Budget Refinement Act was adopted and mandated further cost containing efforts regarding Medicare Part B expenses. In addition, the Medicare, Medicaid and State Children's Health Insurance Program Benefits Improvement and Protection Act of 2000 and The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 include language that affects payment under OPPS. All of which are efforts to control expenses and healthcare cost being paid out of the Medicare Trust Fund. The CY 2007 updates will again strengthen cost containment payments through the OPPS.

Updates Affecting OPPS Payments for CY 2007 (page 67968)

Recalibration of APC Relative Weights for CY 2007

Database Construction

There is a requirement that the relative payment weights for APCs are revised at least annually. In the CY 2007 proposed rule, CMS proposed to use the same methodology that was described in the April 7, 2000 final rule. For CY 2007, claims for hospital outpatient department services furnished on or after January 1, 2005, and before January 1, 2006, were used to recalibrate the APC relative payment weights. CMS also will continue to use single procedure claims to set the medians on which the APC relative payment weights are based. Commenters urged CMS to continue to find ways to use all data from multiple procedure claims to set the median costs. CMS will continue to use a

bypass list of codes to create "pseudo" single claims. The list of codes starts on page 67972 of the *Federal Register.*

The methodology for calculating the overall cost-to-charge ratios (CCRs) will change. The calculation used by CMS and fiscal intermediaries has been different, resulting in higher CCRs by the fiscal intermediaries (FIs). The overall median CCR for the traditional calculation was 0.3040 and using the FI calculation 0.3309. This was due to several factors, but one was attributable to the inclusion of allied health costs for the over 700 hospitals with allied health programs. This was inappropriate because CMS already reimburses hospitals for the costs of these programs through cost report settlement. After considering comments, CMS is adopting the proposal for CY 2007 to issue a Medicare program instruction to fiscal intermediaries that will instruct them to recalculate and use the hospital-specific overall CCR.

Calculation of Median Costs for CY 2007

There is a detailed discussion on pages 67985-67989 on the process used to calculate the rates. The process was finalized in the final rule as well as the list of packaged services by revenue code listed in Table 2 starting on page 67989.

Calculation of Scaled OPPS Payment Weights

Using median APC costs, the final relative payment weights were calculated for each APC for CY 2007 shown in Addenda A and B. In prior years, all relative payment weights were scaled to APC 0601 (Mid Level Clinic Visit) because it was the most frequently performed service in the hospital outpatient setting. Because this APC was deleted, the relative payment weights are scaled to APC 0606 (Level 3 clinic Visit) with a weight of 1.00.

Changes to Packaged Services

Payments for packaged services under OPPS are bundled into the payments providers receive for separately payable services provided on the same day and are identified by the status indicator "N". The review of HCPCS codes will result in the following:

- Maintain packaged status for revised code 0069T
- Package new CPT codes 0174T and 0175T
- Package new CPT codes 0174T and 0175T
- Maintain packaged status for 36500
- Maintain packaged status for 74328, 74329, and 74330 (these codes should be reported with CPT codes 43260-43272)
- Pay separately for 76000, other than 71023 or 71024
- Maintain packaged status for 76001, 76003 and 76005
- Maintain packaged status for 76937 and 77001 (which replaces code 75998)
- Maintain packaged status for 94760, 94761
- Assign codes 36540, 36600, 38792, 75893, 94762, 96523 a status indicator "Q" as a "special" packaged code. See table 3 (page 67996) for status indicators and APC assignments for these "special" packaged codes when they are separately payable.
- Maintain packaged status for G0269 (this code should never be billed without another separately payable procedure)

- Assign status indicator "A" to P9612 and P9615 (payable on the clinical lab fee schedule)

CY 2007 Hospital Outpatient Outlier Payments
After considering comments, CMS is finalizing the proposed policy for CY 2007 outlier payments. Recalculation of the fixed outlier threshold using this methodology results in a fixed-dollar outlier threshold of $1,825 and a multiple threshold of 1.75, based on an outlier estimate of 1.0 percent of payments projected to be made under the CY 2007 OPPS and outlier payments to be made at 50 percent of the amount by which the cost of furnishing the service exceeds 1.75 times the APC rate.

OPPS Ambulatory Classification (APC) Group Policies (page 68014)

Treatment of New HCPCS and CPT Codes

<u>Treatment of New HCPCS Codes Included in the Second and Third Quarterly OPPS Updates for CY 2006</u>
Four new J codes were given pass-through status "G". They are: J2248, J3243, J1740 and J0129.

<u>Treatment of New CY 2007 Category I and III CPT Codes and Level II HCPCS Codes</u>
A list of codes with comment indicator "NI" (new code; interim APC assignment) is available in Addendum B. This indicates new codes that are open to public comment.

Two level II HCPCS codes were created, G0392 and G0393 and will be assigned to APC 0081 with a CY 2007 final median cost of $2,450.64. Beginning in CY 2007, CPT codes 35475 and 35476 should not be reported for patients undergoing percutaneous transluminal balloon angioplasty of hemodialysis access fistulas or grafts.

<u>Treatment of New Mid-Year CPT Codes</u>
After considering several comments, CMS is finalizing the general proposal made in the proposed rule for the treatment of new mid-year CPT codes, with modification only to the CY 2007 APC assignments for Category III CPT codes 0160T and 0161T as described in Table 6 on page 68016.

New Technology APCs

<u>Movement of Procedures from New Technology APCs to Clinical APCs</u>
Usually a procedure is kept in the New Technology APC to which it is initially assigned until enough data has been collected to move it to the clinically appropriate APC.

The following changes were made:
- Nonmyocardial Positron Emission Tomography (PET) Scans (codes 78608, 78811, 78812 and 78813) moved from new technology APC 1513 to APC 0308
- PET/Computed Tomography (CT) Scans (codes 78814, 78815, and 78816) assigned to new technology APC 1514

- Stereotactic Radiosurgery (SRS) Treatment Delivery Services codes have been reassigned to clinically appropriate APCs
    - G0173 and G0339 to APC 0067, G0251 to APC 0065 and G0340 to APC 0066
- Magnetoencephalography (MEG) Services codes have been reassigned to clinically appropriate APCs
    - 95965 to APC 0038 and 95966 and 95967 to APC 0209
- There were 23 other procedures assigned to New Technology APCs that had enough data to reassign them to clinically appropriate APCs. The Table 10 on page 68035 lists these changes.

APC-Specific Policies

<u>Radiology Procedures</u>
CMS has adopted the APC Panel recommendation to not adopt implementation of the multiple procedure reduction policy for imaging services for CY 2007.

CMS also accepted the APC Panel's recommendation to review the CY 2007 proposed payment rates for CT and CTA procedures to ensure that their rates were comparatively consistent and accurately reflective of hospitals' resource costs. After carefully considering the public comments received, CMS finalized their proposal for payment of APCs 0333 and 0662 based on their median costs established according to the standard OPPS methodology, without modification.

CMS also did not propose any changes to APC assignments for CT, MRI and MRA services, and this was finalized. G0299, Reconstruction, computed tomographic angiography of aorta for surgical planning for vascular surgery was assigned to APC 0417 with a median cost of $197.95 assigned.

The proposal was finalized without modification to assign CPT codes 0144T through 0151T to APC 0282, 0376, 0377, and 0398, all with status indicator "S." The table listing the specific APCs for these codes is available on page 68038.

The assignment of CPT code 36598 to APC 0340 for CY 2007 was maintained, and will be reevaluated when data becomes available.

<u>Nuclear Medicine and Radiation Oncology Procedures</u>
Public comments were considered, but CMS is finalizing the APC assignments as proposed. Codes 78459, 78491, and 78492 are assigned to APC 0307. Table 12 on page 68041 lists the specific details.

APC 0651 (Complex Interstitial Radiation source application) contains only one code, CPT code 77778. The coding, APC assignment, median cost, and resulting payment rate for CPT code 77778 have not been stable since the inception of OPPS. The vast majority of claims for interstitial brachytherapy are for the treatment of patients with prostate cancer. A median cost was developed for APC 0651 and proposed. As proposed, CMS believes that the summed median cost for APC 0651 and 0163 results in an appropriate

level of full payment for the dominant type of service provided under APC 0651. They proposed to use the median cost of $1,028.93 as derived from all single bills for APC 0651 according to standard OPPS methodology. CMS recognized that prostate brachytherapy was not the sole use of CPT code 77778. The proposal to develop a median cost for APC 0651 using single procedure claims and general OPPS methodology was finalized.

The proposal to provide payment for proton beam therapy through APCs 0664 and 0667, with payment rates based on the final APC median costs of $1,154 and $1,381 respectively was finalized.

The proposal was finalized to assign CPT code 78730 to APC 0340 with a median cost of #37.29.

None of the options presented by commenters were accepted, and CMS is finalizing CY 2007payment rate for APC 0314 based on its median cost of $204, calculated using CY 2005 claims data as proposed.

CMS is also finalized its proposal for assignment of CPT code 77799 to APC 0312, without modification.

<u>Cardiac and Vascular Procedures</u>
CMS accepted the APC Panel recommendation and will continue to assign CPT codes 93609, 93613 and 93631 to APC 0087.

CMS proposed to reassign CPT codes 36478 and 36479 from APC 0091 to APC 0092 with a proposed median cost of $1,518.22 and was finalized for CY 2007.

After comments, CMS has modified its proposal and will reassign CPT codes 33218 and 33220 from APC 0106 to APC 0105. The titles of these APCs are also revised to reflect the changes. See page 68047 for title changes.

The proposal has been finalized for APC assignments of CPT codes 37184, 37185, 37186, 37187, and 37188 with modification. All five procedures are assigned to APC 0088 for CY 2007.

<u>Gastrointestinal and Genitourinary Procedures</u>
A request was made by the APC Panel to reassign CPT code 57267 to a more clinically and resource appropriate APC. For CY 2007 this code will be reassigned to APC 0195 with a status indicator “T”.

CMS also accepted the APC Panel’s recommendation to reassign CPT code 0135T to APC 0423 for CY 2007.

CPT codes 0071T and 0072T are assigned to APC 0195 as proposed.

As proposed, CPT code 52648 is assigned to APC 0429 for CY 2007 with a median cost of $2,633.85.

The proposal to calculate the median cost of APC 0384 using only claims that pass the device edits and which do not contain token charges for the device HCPCS codes on the claims was finalized. The median cost of APC 0384 is $1,400.71.

CMS also finalized the proposal for assignment of CPT code 43257 to APC 0422 for CY 2007 with a median cost of $1,573.89.

Ocular Procedures

CMS has also adopted the proposal without modification to assign CPT code 65770 to APC 0293 with a median cost of $3,177.05 for CY 2007. They are also assigning a procedure-to-device edit for CPT code 65770 with APC 0293.

The proposal was also finalized for CY 2007 for APCs 0232, 0235, and 0241 without modification, with final median costs of $370.77, $240.36, and $1,543.32, respectively.

The proposal was finalized for HCPCS code V2790 for status “N” status.

Other Procedures

For CY 2006 the American Medical Association (AMA) made comprehensive changes, including code additions, deletions, and revisions, accompanied by new and revised introductory language, parenthetical notes, subheadings and cross-references, to the Integumentary, Repair subsection of surgery. Thirty-seven new CPT codes were created and these codes received interim final status indicators and APC assignments in the CY 2006 final rule.

Upon recommendations by the APC Panel, a proposal was made and finalized to assign these codes as shown in Table 16 on page 68057 in the *Federal Register.*

CMS finalized the proposal without modification to reconfigure CY 2006 APC 0046 for fracture and dislocation procedures into three new APCs for CY 2007, APCs 0062, 0063, and 0064. These are displayed in Table 17 on page 68058.

CPT code 13151 was more appropriately assigned to APC 0025 for CY 2007.

CMS accepted the APC Panel’s recommendation to assign CPT codes 0171T and 0172T to APC 0050 with status indicator “T” for CY 2007.

Medical Services

The proposed policy was finalized without modification to continue to assign status indicator “B” to CPT codes 0115T, 0116T and 0117T for CY 2007.

CMS finalized the proposed methodology for estimating a “per unit” median cost for HCPCS code C1300, assigned to APC 0659.

They also finalized the proposal to assign CPT codes 95873 and 95874 to APC 0215 for CY 2007 without modification.

The structure for APC 0344 was also finalized as proposed. The final CY 2007 median cost of APC 0344 is $48.44 upon which its payment rate is based.

OPPS Payment Changes for Devices (page 68063)

Device-dependent APC medians will be based on CY 2005 claims, which is the most current data available for this group. As a result of the 2005 device edits CMS received many comments that has caused them to remove the requirement for edits for several APCs on the basis that the services within the APC does not always require the use of a device or because no suitable device code is available.

CMS determined that in order to develop the payment rates of CY 2007 that only claims that met the device edits and that did not contain token charges for devices were the appropriate claims to be utilized to set the median costs for those device dependent APCs. For a list of median costs refer to Table 18 on page 68069 which lists the median costs of device dependent APCs for CY 2007.

CMS also identified instances in which hospitals billed a device code with no accompanying procedure code. As a result of these billing errors, the Final Rule for CY 2007 contains provisions for new device to procedure code edits that will be implemented in an effort to reduce billing errors. These edits will become effective with the January 2007 OCE and can be found in Table 19 on page 68071.

CMS has also proposed a revision to existing regulations regarding payment and co-payments for replaced devices. In situations where the device is replaced or removed due to warranty, field action, voluntary recall, involuntary recalls or if the device was provided free of charge the APC payment rate will be reduced. In addition, CMS would expect the patient's co-payment to be reduced as well. In Tables 20 and 21 on page 68077, CMS lists specific APCs and devices which are subject to offset percentages and reporting requirements for CY 2007.

The proposed rule indicates that no category codes for pass through devices will expire on January 1, 2007.

OPPS Payment Changes for Drugs, Biologicals and Radiopharmaceuticals (page 68079)

The Act provides for temporary additional payment in the form of "pass through" payments for certain drugs and biological agents. Under the Act pass through payments can be made for at least 2 years but no more than 3 years. In Table 23 on page 68083, a list of the drugs and biologicals with pass-through status in CY 2007 can be found. There are twelve (12) total revisions/removals from the list.

CMS proposes to continue the pass through status for the drug and biologicals listed in Table 24 that originally received their pass-through status on April 1, 2006.

Under the CY 2009 OPPS Final Rule, payment for drugs, biological and radiopharmaceuticals that do not have pass-through status are paid either based on a packaged payment bundled in with the payment for the service or by a separate payment via a separate APC. In CY 2007, CMS will calculate an annual update to the OPPS packaging threshold using the proposed methodology without any modifications. Drugs, biologicals and radiopharmaceuticals that are not new and do not have a pass-through status will continue to be packaged if their calculated cost per day is less than $55.00.

CMS will continue to have payment for specific covered outpatient drugs. These drugs, biologicals and radiopharmaceuticals will continue to be paid at the rate of the ASP + 6%.

CMS will accept the recommendation of the APC Panel to continue the intravenous immune globulin (IVIG) preadministration-related services payment in CY 2007. Additionally, Medicare will temporarily allow a separate payment in CY 2007 for each day of IVIG administration to both physicians and hospital outpatient departments.

Brachytherapy Source Payment Changes (page 68102)

CMS finalized the proposal to make prospectively paid brachytherapy sources subject to the outlier provisions. As described on page 68107, information was inadvertently omitted from the proposed rule, so a careful review of the final rule is indicated.

After considering public comments received as well as the recommendations of the APC Panel, the Practicing Physicians Advisory Council (PPAC) and the Government Accountability Office (GAO), CMS has decided to base payment for all sources of brachytherapy for which they have CY 2005 claims on their median unit costs derived from CY 2005 OPPS claims data. Refer to Addendum B for the CY 2007 national payment rates and copayments for the sources of brachytherapy. A new code, A9527, has the same brachytherapy source as the predecessor C-code, C2623. Effective January 1, 2007, the C-code will be deleted and crosswalked to A9527. Table 30 on page 68110 contains the median costs of brachytherapy sources.

CMS has finalized the proposed payment methodology for brachytherapy sources based upon their median unit costs from CY 2005 claims data for CY 2007 without modification. While this methodology is fully consistent with the statutory requirement of separate payment for brachytherapy sources based on their number, isotope, and radioactive intensity, it will also provide hospitals with an incentive to operate efficiently in providing brachytherapy services to Medicare beneficiaries.

The proposal to change the definition of status indicators “H” and “K” was finalized.

Table 30 on page 68110 provides a complete listing of the HCPCS codes, long descriptors, APC assignments, median costs, and status indicators for brachytherapy sources paid separately under the OPPS in CY 2007.

Changes to OPPS Drug Administration Coding and Payment for CY 2007 (page 68115)

Drug Administration Coding Changes for CY 2007

CMS has adopted the full set of CPT drug administration codes for 2007. HCPCS code C8957 (Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than 8 hours), requiring the use of portable or implantable pump) will be maintained for use in the 2007 OPPS because there is no comparable CPT code available to report this service. Hospitals are expected to report all drug administration CPT codes in a manner consistent with their descriptors, CPT instructions, and correct coding principles.

The table below lists the newly recognized drug administration CPT codes, 2007 APC assignments (where applicable), and associated status indicators. This table can also be found on page 68117 of the final rule (Table 32).

CY 2007 Newly Recognized Drug Administration CPT Codes

2007 CPT Code	2007 Description	2007 APC	2007 Status Indicator
90760	Intravenous infusion, hydration; initial, up to one hour	0440	S
90761	Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)	0437	S
90765	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to one hour	0440	S
90766	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)	0437	S
90767	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion, up to 1 hour (List separately in addition to code for primary procedure)	0437	S
90768	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure)	–	N
90774	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	0438	S

2007 CPT Code	2007 Description	2007 APC	2007 Status Indicator
90775	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)	0438	S
96409	Chemotherapy administration; intravenous, push technique, single or initial substance/drug	0439	S
96411	Chemotherapy administration; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure)	0439	S
96413	Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug	0441	S
96415	Chemotherapy administration, intravenous infusion technique; each additional hour (List separately in addition to code for primary procedure)	0438	S
96417	Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to 1 hour	0438	S

CMS plans to issue instructions that will provide OPPS-specific guidance for hospital outpatient departments providing drug administration services in 2007.

Drug Administration Payment Changes for CY 2007

In 2007, drug administration services will be reimbursed through a six-level APC structure, with separate payment for each hour of drug infusion. Using this structure should allow CMS to make more accurate payments to hospitals for complex and lengthy drug administration services furnished to Medicare beneficiaries for many medical conditions, while also providing accurate payments for individual services when provided alone.

Payment rates for the new drug administration APCs are based on median costs for the APCs as calculated from CY 2005 claims data. The payment for CPT code 90768 (Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion) is packaged in 2007 because concurrent infusions were not previously separately reported in the OPPS and their costs are already packaged into the 2007 payments.

Because the newly recognized CPT codes discriminate among services more specifically than the 2006 C-codes, as was the case when the OPPS transitioned from more general Q-codes to more specific CPT codes for the reporting of drug administration services in 2005, for a period of two years, drug administration services will be paid based on the costs of their predecessor HCPCS codes until updated data are available for review.

The six-level drug administration APC structure is shown in the table below. This table can also be found on page 68123 of the final rule (Table 34).

CY 2007 Final Six-Level Drug Administration APC Structure

Final 2007 APC	Final APC Status Indicator	Final 2007 APC Median Cost	CPT/HCPCS Code	Description
0436	S	$11.06	90472	Immunization admin, ea add vaccine
			90473	Immunization admin, oral/nasal, 1 vaccine
			90474	Immunization admin, oral/nasal, ea add vaccine
			90779	Unlisted ther/proph/diag injection/infusion
			95115	Allergen immunotherapy, 1 injection
			96549	Unlisted chemo proc
0437	S	$24.11	90471	Immunization admin, 1 vaccine
			90761	IV hydration infusion, ea add hr
			90766	Ther/proph/diag IV infusion, ea add hr
			90767	Ther/proph/diag IV infusion, add seq infusion, 1 hr
			90772	Ther/proph/diag injection, subc or IM
			95117	Allergen immunotherapy, 2 or more injections
			95145-95170	Antigen therapy services
0438	S	$48.53	90773	Ther/proph/diag injection, intra-arterial
			90774	Ther/proph/diag injection, IV push
			90775	Ther/proph/diag injection, ea add seq IV push
			96401-96402	Chemo admin, subc or IM
			96405-96406	Chemo admin, intralesional
			96415	Chemo admin, IV infusion, ea add hr
			96417	Chemo admin, IV infusion, ea add seq infusion
			96423	Chemo admin, intra-arterial, infusion technique, ea add hr
			96542	Chemo injection, subarachnoid or intraventricular via subc reservoir
0439	S	$96.85	96409	Chemo admin, IV push, single drug

Final 2007 APC	Final APC Status Indicator	Final 2007 APC Median Cost	CPT/HCPCS Code	Description
			96411	Chemo admin, IV push, ea add drug
			96420	Chemo admin, intra-arterial, IV push
0440	S	$110.55	90760	IV hydration infusion, init
			90765	Ther/proph/diag IV infusion, init
			96521	Refill/maint, portable pump
			96522	Refill/maint implantable pump/reservoir system
0441	S	$151.86	96413	Chemo admin, IV infusion, 1 hr
			96416	Chemo admin, IV infusion, prolonged infusion with pump
			96422	Chemo admin, intra-arterial infusion, 1 hr
			96425	Chemo admin, intra-arterial, prolonged infusion with pump
			96440	Chemo admin, pleural cavity
			96445	Chemo admin, peritoneal cavity
			96450	Chemo admin, into CNS
			C8957	Prolonged IV infusion, requiring pump

Hospital Coding and Payment for Visits (page 68124)

Clinic Visits

CMS had proposed the establishment of HCPCS codes ("G" codes) to describe hospital clinic and emergency department visits and critical care services. In response to a number of comments indicating that it would be difficult to first transition to G codes and then to transition to national guidelines shortly thereafter, CMS has postponed implementation of G codes for clinic visits until national guidelines have been established. Because hospitals will continue to use CPT codes in 2007, they must continue to distinguish among new, established, and consultation visits. CMS will need to determine whether there should be a distinction between new and established visits and consultations in the national guidelines under development.

CMS does not want to create an incentive for hospitals to bill a consultation code instead of a new or established patient code, as they do not believe that consultation codes necessarily reflect different resource utilization than either new or established patient codes. Therefore, they have moved the consultation codes to the same APC as the established patient code, for each level of service. CMS indicated that it may be unnecessary for hospitals to report consultation CPT codes if either the new or established patient visit code accurately describes the service provided.

Emergency Department Visits

CMS had proposed a series of G codes to differentiate Type A and Type B emergency departments. Under the OPPS, the billing of emergency department CPT codes has been restricted to services furnished at facilities that meet the CPT definition of an emergency department. The 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." In the proposed rule, emergency departments that meet the CPT definition were referred to as type emergency departments. There are some emergency departments that meet the definition of a dedicated emergency department under the Emergency Medical Treatment and Labor Act (EMTALA), but do not meet the more restrictive CPT definition. This type of emergency department was referred to in the proposed rule as Type B emergency departments. Because these departments do not meet the requirement for reporting the CPT emergency department codes, they must bill clinic visit codes. CMS has had no way to distinguish costs of visits provided in emergency departments that do not meet the CPT definition.

CMS has decided to postpone finalization of G codes for Type A emergency departments until national guidelines have been developed. However, for 2007, they are implementing a set of G codes for Type B emergency departments. These new codes are necessary in order to distinguish between clinics, Type A emergency departments, and Type B emergency departments. A Type A emergency department is a hospital-based facility or department that is open 24 hours a day, 7 days a week, and meets at least one of the following requirements: (1) It is licensed by the State in which 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. A Type B emergency department is a hospital-based facility or department that meets 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; (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; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

Although there are no changes in payment policy in 2007 for Type B emergency departments (services in Type B emergency departments will still be paid as clinic visits), the reporting of specific G codes for visits to Type B emergency departments will permit CMS to specifically collect and analyze the hospital resource costs of visits to these facilities in order to determine an alternative payment policy may be warranted in the future. The HCPCS codes for emergency department visits in Type B emergency departments are listed in the table below and on page 68130 in the final rule (note that the

codes for level 4 and 5 visits are incorrect in Table 37 in the final rule, but they are listed correctly in Addendum B of the final rule).

Type B Emergency Department HCPCS Codes

HCPCS Code	Short Descriptor
G0380	Lev 1 hosp type B ED visit
G0381	Lev 2 hosp type B ED visit
G0382	Lev 3 hosp type B ED visit
G0383	Lev 4 hosp type B ED visit
G0384	Lev 5 hosp type B ED visit

Critical Care Services

CMS has decided to pay differentially for critical care when there is trauma activation associated with the critical care and when there is no trauma activation. Hospitals will continue to report CPT codes 99291 and 99292 for critical care. A new HCPCS code, G0390, has been created for trauma response team activation associated with hospital critical care services. This code will be reported in addition to the appropriate CPT code for critical care. When G0390 is reported, APC 0618, Critical Care with Trauma Response, will be assigned. Only one unit of G0390 will be reimbursed per day.

Number of Payment Levels

Clinic and emergency department visits will be paid at five levels instead of three. Five payment levels will increase the payment rates for the highest level clinic and emergency department visits, which will benefit hospitals that provide these high-level services. CMS does not anticipate that hospitals will need to update their internal guidelines to reflect this change, as it affects payment, not coding.

The following table shows the assignment of claims data from the 2005 CPT codes and other codes in the Visit APCs to the new VISIT APCs for 2007. This table can also be found on page 68139 in the final rule (Table 42).

Final Assignment of Claims Data from CY 2005 CPT Codes and Other HCPCS Codes to New Visit APCs for CY 2007

CY 2007 APC Title	CY 2007 APC	HCPCS Code	Short Descriptor
Level 1 Hospital Clinic Visits	0604	92012	Eye exam established pat
		99201	Office/outpatient visit, new (Level 1)
		99211	Office/outpatient visit, est (Level 1)
		G0101	CA screen; pelvic/breast exam
		G0245	Initial foot exam pt lops
		99241	Office consultation (Level 1)
		99271	Confirmatory consultation (Level 1)
		G0264	Assmt otr CHF, CP, asthma
Level 2 Hospital Clinic Visits	0605	92002	Eye exam, new patient
		92014	Eye exam and treatment
		99202	Office/outpatient visit, new (Level II)

CY 2007 APC Title	CY 2007 APC	HCPCS Code	Short Descriptor
		99212	Office/outpatient visit, est (Level II)
		99213	Office/outpatient visit, est (Level II)
		99243	Office consultation (Level III)
		99242	Office consultation (Level II)
		99273	Confirmatory consultation (Level III)
		99272	Confirmatory consultation (Level II)
		99431	Initial care, normal newborn
		G0246	Follow-up eval of foot pt lop
		G0344	Initial preventive exam
Level 3 Hospital Clinic Visits	0606	92004	Eye exam, new patient
		99203	Office/outpatient visit, new (Level III)
		99214	Office/outpatient visit, est (Level IV)
		99274	Confirmatory consultation (Level IV)
		99244	Office consultation (Level IV)
Level 4 Hospital Clinic Visits	0607	99204	Office/outpatient visit, new (Level IV)
		99215	Office/outpatient visit, est (Level V)
		99245	Office consultation (Level V)
		99275	Confirmatory consultation (Level V)
Level 5 Hospital Clinic Visits	0608	99205	Office/outpatient visit, new (Level V)
		G0175	OPPS service, sched team conf
Level 1 Emergency Visits	0609	99281	Emergency dept visit (Level I)
Level 2 Emergency Visits	0613	99282	Emergency dept visit (Level II)
Level 3 Emergency Visits	0614	99283	Emergency dept visit (Level III)
Level 4 Emergency Visits	0615	99284	Emergency dept visit (Level IV)
Level 5 Emergency Visits	0616	99285	Emergency dept visit (Level V)

National Guidelines for Coding Facility Visits

CMS contracted a validation study of a modified version of the facility visit guidelines developed by AHIMA and the American Hospital Association (AHA). No conclusions could be drawn concerning the relationship between the distribution of current hospital reporting of visits using CPT evaluation and management (E/M) codes that are assigned according to each hospital's internal guidelines and the distribution of code levels under

the modified AHA/AHIMA guidelines. CMS was also unable to demonstrate a normal distribution of visit levels under the AHA/AHIMA guidelines. Despite the inconclusive findings from the validation study, CMS believes the AHA/AHIMA guidelines are the most appropriate and well-developed guidelines for use in the OPPS of which they are aware. However, they require short-term refinement prior to their full adoption by the OPPS.

Outstanding concerns with the AHA/AHIMA guidelines are:

1. Three vs. five levels of codes: Since CMS is now going to pay at five payment levels for 2007, the AHA/AHIMA guidelines may need to be revised to reflect five visit levels.
2. Lack of clarity for some interventions: Some interventions are vague, unclear, or nonspecific, without sufficient examples of documentation in the medical record that may support those interventions.
3. Treatment of separately payable services: Although AHA and AHIMA were originally directed to exclude separately payable services from their guidelines, CMS is now open to reconsidering whether the inclusion of some separately payable services could serve as a proxy for the resources that the patient will consume and that should be attributable to the hospital visit, not the separately payable services. When separately payable interventions are removed from the model, it may be difficult for the limited interventions remaining in the guidelines for each visit level to capture the acuity level of the patient.
4. Some interventions appear overvalued: Several interventions that CMS believes may be minor are valued at a high level in the guidelines.
5. Concerns of specialty clinics: The AHA/AHIMA guidelines are unlikely to sufficiently address the concerns of various specialty clinics (for example, pain management clinics, oncology clinics, and wound care clinics). While CMS prefers to have one model that can be applied nationally to each level of clinic visit code for which they make a specific OPPS payment, they are unsure as to whether one model can adequately characterize visit levels for all types of clinics.
6. Americans with Disabilities Act: The intervention in the AHA/AHIMA guidelines that relates to the special needs of certain patients may be in violation of the Americans with Disabilities Act, as it may increase the visit level reported, thereby increasing a patient's copayment.
7. Differentiation between new and established patients and between standard visits and consultations: The AHA/AHIMA guidelines do not differentiate between new versus established patients or consultations versus standard visits for clinic visits. Several years of hospital claims data consistently indicate that new patients generally are more resource intensive than existing patients across all visit levels, and that consultations are more resource intensive than standard visits, but similar in terms of resources to new patient visits.
8. Distinction between Type A and Type emergency departments: There are no AHA/AHIMA guidelines for the reporting of visits to Type B emergency departments that meet the EMTALA definition of an emergency department, but do not meet the definition of a Type A emergency department. At the time the AHA/AHIMA guidelines were developed, emergency departments that did not

meet the CPT definition of emergency department were instructed to bill CPT clinic visit codes.

CMS continues to commit that they will provide a minimum of 6-12 months notice to hospitals prior to implementation of national guidelines to provide sufficient time for providers to make the necessary systems changes and educate their staff.

Payment for Blood and Blood Products (page 68146)

Since the beginning of the OPPS, CMS has separated payments for blood and blood products through APCs rather than packaging them into the cost of the procedure that they were administered for. For CY 2007, payment rates for blood and blood products will be based on their median cost from CY 2005. Seven (7) of the blood products will be reimbursed at 75% of the CY 2006 adjusted median cost because their CY 2007 would have resulted in a payment decrease of greater than 25%. This step is considered to be a payment transition for these seven products and is not meant to occur each year. A full listing of the payment costs for CY 2007 blood and blood products can be found on Table 43 on page 68149.

OPPS Payment for Observation Services (page 68150)

In CY 2006 CMS proposed that observation services reported with HCPCS code G0378 are eligible for a separate payment under APC 0339. Due to relatively stable service costs in APC 0339, the reimbursement for this APC will increase only slightly in CY 2007. Table 44 on page 68152 identifies diagnosis codes for separate payment of observation services if all criteria are met. CMS will continue to include in the October quarterly update of the OPPS any changes to this list. This list specifically pertains to those cases in which the hospital can bill separately for the observation with HCPCS code G0378

Direct admissions to observation (HCPCS code G0379) will change from APC 0600 to reimbursement under APC 0604 (Level 1 Clinic Visits) and result in a slight decrease in hospital payment.

CMS continues to feel that the changes to observation reimbursement outlined in the final rule will allow for more consistent hospital billing of these services. In addition, CMS feels that these changes will assist in future analyses of reimbursement data in regards to payments made for observation services in order to continue to simplify the process.

Procedures that will only be paid as Inpatient Procedures (page 68154)

A total of 20 procedures will be removed from the Inpatient Only list. A complete list of the procedures that have been removed along with their corresponding APC is listed in

Table 46 on page 68156. Eight (8) procedures were removed through input received from the CMS clinical panel. Ten (10) procedures were removed through input from the APC Review Panel and an additional two (2) procedures were removed as a result of public comment.

OPPS Payment Status and Comment Indicators (page 68160)

CY 2007 Status Indicator Definitions

The OPPS payment status indicators assigned to HCPCS codes and APCs play an important role in determining payment for services under OPPS. The final status indicators for items and services that are paid under the OPPS are listed on page 68163.

CY 2007 Comment Indicator Definitions

After consideration of comments, CMS is implementing the comment indicators as proposed for CY 2007, with modification to the definition of comment indicator "CH" to include active HCPCS codes that are discontinued at the end of the current calendar year.

Policies Affecting Ambulatory Surgical Centers (ASCs) for CY 2007 (page 68164)

ASC Background

ASC procedures are those surgical and other medial procedures that are

- Commonly performed on an inpatient basis but may be safely performed in an ASC;
- Not of a type that are commonly performed or that may be safely performed in physicians offices;
- Limited to procedures requiring a dedicated operating room or suite and generally requiring a post-operative recovery room or short-term (not overnight) convalescent room; and
- Not otherwise excluded from Medicare coverage.

ASC List Update Effective for Services Furnished On or After January 1, 2007

In the CY 2007 OPPS proposed rule, no changes were proposed to the criteria for adding or deleting items from the ASC list. However, CMS did discuss proposed changes in the context of developing a revised ASC payment system to be effective January 1, 2008. The proposed changes to the criteria would result in the addition for CY 2008 of many procedures that do not meet the current criteria for addition to the list. CMS expects the final rule that will implement the revised ASC payment system effective January 1, 2008 to be published as a separate document in the spring of 2007.

Currently, procedures on the ACS list are assigned to one of nine payment groups based on CMS' estimate of the costs incurred by the facility to perform the procedure. No changes in the nine groups were made.

The list of procedures that are covered when furnished in an ASC has been updated and is effective January 1, 2007. CMS proposed 14 procedures to be added to the ASC list. CMS received many comments requesting additional changes. The final additions are shown in Table 47-B on page 68168. And the G-codes and other additions to the list in response to comments are displayed in Table 48 on page 68170.

Table 49 on page 68170 lists the procedures not added because they are predominantly performed in the physician's office. Table 50 lists procedures not added to the CY 2007 ASC list because they do not meet current clinical criteria for addition. The complete list of ASC rates and groups by CPT code is available in Addendum AA beginning on page 68243.

Reporting Quality Data for Improved Quality and Costs under OPPS (page 68189)

CMS wants to ensure that the expenditures on Medicare services are directed towards quality services that have a positive impact on a beneficiary's health. The need for this initiative is accelerated due to the growth rate of hospital outpatient services. CMS explored the concept of "value-based purchasing" that is utilized in other Medicare payment systems. Value-based purchasing is intended to promote efficient use of resources while providing better quality. The inpatient prospective payment system (IPPS) is affected by the initial ten starter quality measures and was recently expanded to include an additional twenty-one indicators. The indicators are pertinent for the following diagnoses: acute myocardial infarction, heart failure, pneumonia. Surgical care improvement project measurers were also added for fiscal year 2007. CMS initially proposed to utilize the same quality measures that are reported for IPPS, for the OPPS starting with calendar year 2007, and begin work on specific measures for outpatient services. The rationale was that the current measures do reflect services that are provided in an outpatient setting prior to admission, as most hospitals function as a system to provide services regardless of an inpatient or outpatient designation. CMS had also proposed to reduce the OPPS conversion factor by two percent in calendar year 2007 for those facilities that are eligible to participate in the IPPS quality measures but have failed to comply with the program. After analyzing the public comments, CMS has decided to wait until calendar year 2009 to implement a reporting program for hospital outpatient services. This will allow time to develop measures specific to hospital outpatient services utilizing a similar infrastructure that the inpatient quality measures utilize. Subsequently, the two percent reduction in the conversion factor will also be delayed until calendar year 2009 for those facilities that do not comply with the program. CMS plans to "work quickly and collaboratively with the hospital community to develop and implement quality measures for the OPPS that are fully and specifically reflective of the quality of hospital outpatient services."

Promoting Effective use of Health Information Technology (page 68197)

The proposed rule sought public comments in three areas that CMS is focusing on in regards to health information technology (HIT). These areas are as follows: CMS' statutory authority and conditions of participation; role of HIT in value based purchasing; and importance of interoperability standards in promoting the adoption of HIT. CMS will continue to explore implementing value-based purchasing payment systems that encourage the use of HIT. Most comments noted the biggest obstacle of adoption of HIT is current lack of an infrastructure. This issue, which includes the lack of interoperability standards, is being addressed through various public and private collaboration projects to build and support an infrastructure. At this time CMS will not require the adoption of "certified, interoperable HIT as part of the Medicare conditions of participation," however they reserve the right to revisited it a later date.

Additional Quality Measures and Procedures for Hospital Reporting of Quality Data for the FY 2008 IPPS Annual Payment Update (page 68201)

The Deficit Reduction Act of 2005 requires reporting hospital quality data for inpatients stays. The reporting requirements are to be reviewed and expanded upon for each fiscal year. In order to give hospitals as much advanced notice as possible, the additional reporting measures were identified in the OPPS proposed rule. In addition to the current reporting requirements the following areas will be added for fiscal year 2008: Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient perspective survey, surgical care and mortality outcome measures. The HCAHPS survey is intended to supplement current internal customer service initiatives by asking the patient questions in the following seven domains – doctor communication, nurse communication, and cleanliness and quite of the hospital environment, responsiveness of hospital staff, pain control, medication communication, and discharge information. The survey may be self administered by the facility or by a survey vendor with the results being made available to the public. See the final rule for specific details regarding the survey process. The next measurements regarding the surgical care improvement project (SCIP) are venous thromboembolism prophylaxis and antibiotic prophylactic for the surgery patient. Finally the last measure relates to a 30 day mortality rate measure regarding Medicare patients. Mortality measures for the following diagnoses are in the proposed rule--Acute myocardial infarction, heart failure, and pneumonia. Two of the three were adopted in the final rule. The pneumonia mortality measure was not adopted as it is not currently approved by the consensus building entities. As CMS continues to expand its quality efforts, the collaborative relationships will remain important for implementation of quality measurers with the goal of improving the quality of care received by Medicare beneficiaries. CMS will work to provide adequate notice to the hospital community of these measures to ensure proper facility reporting.