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SPECIAL POINTS OF INTEREST:

- 2009 OPPS and ASC Changes
- ICD-10 Proposed Rule
- Medicare Physician Fee Schedule (MPFS) Annual Update.

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Hospital Outpatient Prospective Payment System

On October 30, 2008, the Centers for Medicare & Medicaid Services (CMS) issued a final rule for the Hospital Outpatient Prospective Payment System (OPPS) for calendar year CY 2009. The final rule establishes payment rates and policy changes that will go into effect for services furnished in the hospital outpatient department and the ambulatory surgical centers (ASCs) to Medicare beneficiaries on or after January 1, 2009.

Rate and conversion factor - The final OPPS/ASC System rule includes a 3.6 percent annual inflation update for HOPDs, at least for those hospitals that have met the quality reporting requirements (see next bullet). There is no ASC inflation update for CY 2009.

Quality Measures in Hospital Outpatient Departments - The Medicare law requires that the annual OPPS inflation update be reduced by 2.0 percentage points for certain hospitals that do not meet quality reporting requirements. The final rule adopts four new quality measures for imaging efficiency, for a total of 11 quality measures used to report in CY 2009 in order to get the full CY 2010 update. CMS continues to consider additional quality measures for future annual updates in areas ranging from screening for fall risk to cancer care, many of

which were identified in the CY 2009 proposed rule.

Ambulatory Payment Classification (APC) for imaging services - CMS is changing how Medicare will pay for imaging when two-or-more imaging procedures using the same imaging modality are provided in one session. The final rule creates five new composite APCs: Ultra-

GIRS can help analyze the impact of 2009 changes on your products and associated services in the HOPD and ASC.

sound; Coronary Computed Tomography (CT)/CT Angiography (CTA) without contrast; CT/CTA with contrast; Magnetic Resonance (MR)/MR Angiography (MRA) without contrast; and MR/MRA with contrast. When more than one imaging study from within a grouping is performed in the same session, the hospital will submit the claim as before, but Medicare will issue one bundled APC payment. CMS argues that this will reduce unnecessary tests.

Drugs and Biologicals - For 2009, separately payable drugs and biologicals will be paid at the average sales price plus 4 percent (ASP+4), but only when their average price is above \$60.

Pass-through drugs and biologicals - CMS will continue to pay for pass-through drugs and biologicals at ASP plus 6 percent in CY 2009; equivalent to the rate these drugs and biologicals would receive in the physician's office.

Payment for Therapeutic and Diagnostic Radiopharmaceuticals - As mandated by Section 142 of Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), CMS will continue to pay for therapeutic radiopharmaceuticals at charges adjusted to cost for CY 2009. CMS will continue to package payment for all diagnostic radiopharmaceuticals into the APC payment for their associated nuclear medicine procedures.

Payment for Intravenous Immune Globulin Pre-administration-Related Services - For CY 2009, CMS will package payment for IVIG pre-administration-related services, rather than making a separate payment for these services as CMS did on a temporary basis from CY 2006 to CY 2008.

Source: Final Changes to the Hospital Outpatient Prospective Payment System and CY 2009. CMS-1404-FC. October 30, 2008. <http://www.cms.hhs.gov/HospitalOutpatientPPS/Downloads/CMS-1404-FC.pdf>.

Council On Technology and Innovation (CTI) releases “Innovators Guide to Navigating CMS”

As mandated by the 2003 Medicare Prescription Drug Improvement and Modernization Act (MMA) the Centers for Medicare and Medicaid Services (CMS) established a Council on Technology and Innovation (CTI). The purpose of the CTI is to provide a more streamlined and transparent process for technological advances entering into the medical marketplace by coordinating activities related to coverage, coding, and payment.

In August 2008, CMS released a document called “Innovators’ Guide to

GIRS tracks re-sources to help our clients understand technology reimbursement.

Navigating CMS Version 1.0.” This document, exceeding 50 pages, is the first-ever CMS-generated guide that provides a comprehensive overview of coverage, coding, and payment regulations, as well as processes, timelines, and points of contact at CMS. CTI makes it clear that the guide is intended as a summary and is not legally binding, nor does it contain

complete regulatory or statutory language.

The CMS press release and actual report can be downloaded from the CMS website at

<http://www.cms.hhs.gov/CouncilonTechInnov/>.

The guide both reinforces the strategies GIRS has always recommended to its clients, and enables our customers to be better-informed.

Medicare Physician Fee Schedule (MPFS) Annual Update

On October 30, 2008, CMS released on its website a final rule for the MPFS for CY 2009. The final rules establishes Medicare payment rates and policy changes effective for Medicare services furnished by physicians and non-physician practitioners (NPPs) on or after January 1, 2009.

Conversion Factor - Effective January 1, 2009, the MPFS conversion factor will be \$36.0666.

New Electronic Prescribing Incentive Program - CMS announced a

new initiative for physicians to trade in their prescription pads to improve efficiency and safety when ordering drugs for patients with Medicare. Physicians and other eligible professionals who adopt and use qualified electronic prescribing (e-prescribing) systems to transmit prescriptions to pharmacies may earn an incentive payment of 2.0 percent of their total Medicare allowed charges during 2009.

Annual Therapy Cap -The annual, per beneficiary, therapy cap

for 2009 will be \$1,840 for physical therapy and speech-language pathology services combined and \$1,840 for occupational therapy services separately.

Source:Physician Fee Schedule Federal Regulation Notice. CMS-1403-FC, November 19, 2008.

<http://www.cms.hhs.gov/physicianfeesched/downloads/CMS-1403-FC.pdf?agree=yes&next=Accept>.

GIRS can analyze the final rule and updates to determine how your customers will be impacted by changes in 2009 payment rates and policy initiatives.

The Medicare home health prospective payment system (HH-PPS) Notice for calendar year (CY) 2009

CMS issued a notice to update the Home Health Prospective Payment System (HH PPS) for calendar year (CY) 2009.

Market Basket and Case-Mix Adjustments - CMS adopts a home-health market basket increase of 2.9 percent for CY 2009. The update also accounts for a 2.75 percent reduction in the national 60-day episode

rate.

Quality Data Reporting - As in other settings, there will be a 2 percent payment differential if data on 12 quality measures is not submitted to CMS. For HHAs that submit the required quality data, the updated national standardized 60-day episode rate for CY 2009 will be \$2,271.92.

Non-Routine Medical Supplies -

The non-routine medical supplies (NRS) conversion factor will be \$52.39 for CY 2009.

Source: Home Health Prospective Payment System Rate Update for Calendar Year 2009. CMS-1555-N. October 10, 2008. <http://edocket.access.gpo.gov/2008/pdf/E8-26142.pdf>

GIRS also can help educate customers about changes.



Dynamic Strategies
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- Support and educate providers
- Provide international reimbursement services
- Help providers appeal denials of coverage for your products

Important Notice: Do not print, distribute, edit, or duplicate. This newsletter is for the purpose of providing educational payer trends information for GIRS current and potential clients. It is not intended to increase reimbursement or provide a guarantee to anyone. Coverage and reimbursement are dynamic and change frequently. Every effort will be made to provide the most updated information. This information is current as of December 15, 2008.

ICD-10 Proposed Rule

As you know, CMS has been developing the new ICD-10 system for many years. In August, CMS released a proposed rule about the implementation of the ICD-10-CM and PCS systems. Specifically, CMS' proposed implementation would be on October 1, 2011. On this date CMS would concurrently switch over to the ICD-10-CM diagnosis codes (all settings/all providers) and ICD-10-PCS procedure codes (services performed in inpatient hospitals only). The October 1st timeframe coincides with the inpatient PPS update cycle, and the ICD-10 transition will have the largest impact on hospital inpatient billing and payment systems. CMS also proposes administrative details such as a timeline for testing the system and the establishment of a coordination and maintenance committee.

The rule itself is short and does not contain specifics on the code sets themselves, but the CMS website has numerous resources and details about the code sets. Click on http://www.cms.hhs.gov/ICD10/01_Overview.asp#TopOfPage and select from the choices on the left-hand column.

GIRS can help you understand the impact of the transition to ICD-10 on your customers. GIRS can help you determine which ICD-10 codes will be relevant to your products and whether there are any unique problems or opportunities to address proactively.

There are also stakeholder conference calls held by the agency.

During its comment period, which ended on October 21st, CMS received resistance to the 2011 implementation because it did not allow sufficient time for preparing for the transition and testing the new system, among other things. Instead, they ask for an October 2012 implementation. Protestors also dispute the CMS assumption of how much training would be required for the conversion. The American Health Information Management Association (AHIMA) completed an impact report that it has submitted to CMS for consideration and that report has been made public.