



Coding Compliance Newsletter

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Partners in
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Proposed 2009 OPPS Update

The 2009 OPPS Proposed Rule was published on the CMS website on July 3, 2008 and in the Federal Register on July 18, 2008. Comments on the Proposed Rule are due to CMS on September 2, 2008.

It appears that most of the changes will be financial rather than operational to facilities. The Proposed Rule anticipates an overall 3.2% increase to the Medicare payment rates for most services that would be paid under OPPS.

This newsletter will summarize three (3) issues described in the proposed rule:

1. Composite Imaging APCs
2. Type B Emergency Departments
3. Quality Initiatives

Multiple Imaging Composite APCs

CMS is proposing to create five (5) composite APCs for families of radiological procedures: ultrasound, CT and CTA, and MRI and MRA. Currently (CY 2008) a full APC payment is made for each imaging service on a claim, regardless of how many procedures are performed during a single session using the same imaging modality. The method of reimbursement does not reflect the types of efficiencies hospitals can achieve when multiple imaging procedures are performed during a single session.

To implement this proposed policy, CMS would reimburse the provider one composite APC payment each time a hospital bills more than one procedure in an imaging family (3) on the same date of service. See Table 7 of the Proposed Rule for the Imaging Families (ultrasound, CT and CTA with and without contrast, MRI and MRA with and without contrast) and HCPCS codes.

Hospitals would continue to report the appropriate HCPCS code to report the imaging service. The I/OCE would determine when combinations of imaging procedures would qualify for a composite APC or a standard APC.

Type B Emergency Department Visits

National guidelines for clinic and emergency department (ED) visits were still not published in the proposed 2009 OPPS rule. While waiting the development of the national guidelines, CMS has advised hospitals to develop their own internal guidelines for the clinic and ED that determine the level of care. The guidelines should be designed to reasonably relate the intensity of the hospital resources to the different levels of care represented by the CPT codes.

In 2007 CMS designated two (2) types of emergency departments. The Type A Emergency Department is open 24 hours a day, 7 days a week and must meet EMTALA requirements. There are five (5) CPT E & M emergency department visit codes for the Type A ED. The Type B ED was defined as any ED that met EMTALA regulations but not the Type A ED definition. A set of five (5) G-codes were utilized for hospitals to report a Type B ED visit on the claim. The Type B ED visit is paid at the same rate as a non-emergency visit to the OP department.

CMS now has data that shows that most ED Type B visits are more expensive than clinic visits, but less costly than Type A ED visits. CMS is proposing to pay for Level 1-4 Type B ED visits by creating four (4) new APCs. They are also proposing to pay for a Level 5 Type B ED visit the same as a Type A ED visit. The proposed rule also includes the Level 5 Type B ED visit in the criteria for assigning the Level II Extended Assignment and Management Composite APC.

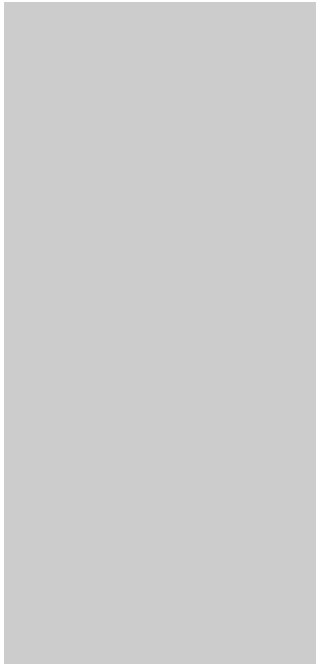
The chart below describes the proposed Type B ED visit APCs and associated median cost:

Type B Emergency Department Visit Level	Proposed CY 2009 APC Assignment	Proposed CY 2009 APC Median Cost
Level 1	0626	\$48.00
Level 2	0627	\$65.00
Level 3	0628	\$92.00
Level 4	0629	\$156.00
Level 5	0616	\$325.00

Quality Initiatives

Currently, in order to receive the full OPPS payment in 2009, hospitals must report data in CY 2008 on seven (7) quality measures of ED and perioperative surgical care. CMS has proposed to add four (4) imaging efficiency measures for 2009. Hospitals that fail to meet the quality initiatives in 2009 will receive a 2.0% reduction to their market basket in 2010.

The proposed additional quality measures are as follows:



Topic	Measure
Imaging Efficiency	OP-8: MRI Lumbar Spine for Low Back Pain OP-9: Mammography Follow-up Rates. OP-10: Abdomen CT – Use of Contrast Material: <ul style="list-style-type: none"> • OP-10: CT Abdomen – Use of Contrast Material. • OP-10a: CT Abdomen – Use of Contrast Material excluding calculi of the kidneys, ureter, and/or urinary tract. • OP-10b: CT Abdomen – Use of Contrast Material for diagnosis of calculi in the kidneys, ureter, and/or urinary tract. OP-11: Thorax CT - Use of Contrast Material.

These services were identified because of growing concerns regarding the overuse of imaging services.

When the Final Rule is published in November 2008, the changes will be effective January 1, 2009.