

# HEALTH LAW

## Update

NEWS FOR THE CLIENTS AND FRIENDS OF BASS, BERRY & SIMS PLC

## CMS Issues Final Rule Updating Outpatient Prospective Payments

December 19, 2006

On November 1, 2006, the Centers for Medicare & Medicaid Services (CMS) issued a final rule revising the Medicare hospital outpatient prospective payment system (OPPS). This rule, published in the Federal Register on November 24, 2006, also implements statutory requirements from the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 and the Deficit Reduction Act (DRA) of 2005 related to OPPS. The final rule will apply to services provided on or after January 1, 2007, unless otherwise specified, and affects a wide range of outpatient services related to OPPS, the hospital inpatient prospective payment system (IPPS), and the ambulatory surgical center (ASC) payment system.<sup>1</sup> Selected provisions of the final rule are briefly described below. Please contact any member of our Healthcare Practice Area listed on the last page if you have questions or need further information regarding the OPPS final rule.

**Increase in Payments to Hospitals.** CMS estimates a 3% average increase in payments to hospital outpatient departments in calendar year (CY) 2007. The final rule includes a 3.4% market basket update to the Medicare payment rates for outpatient services, resulting in a total of \$32.5 billion in payments for Medicare outpatient services for the year. CMS projects a 9.2% increase in Medicare outpatient expenditures in CY 2007 over CY 2006 due to increased utilization and complexity of services.

**Expansion of Quality Reporting and Links to Payment.** Starting in CY 2009, the rule ties OPPS rate increases to hospital reporting on quality measures. Between now and then, CMS plans to develop additional quality measures specific and appropriate to the outpatient setting.

The final rule also expands hospital reporting on quality measures for inpatient services starting in fiscal year 2008. These additional requirements include the reporting of consistent measures on patient satisfaction with hospital care. Hospitals will be required to report on these measures in

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<sup>1</sup> 71 Fed. Reg. 67959 et seq. (to be codified at 42 C.F.R. pts. 410, 416, 419, 421, 485, and 488).

order to receive a full IPPS payment update. Moreover, hospitals will have to report risk-adjusted outcome measures to receive the full payment update.

**Creation of New HCPCS Codes for Emergency Visits to Part-Time Emergency Departments.**

The final rule creates five new Healthcare Common Procedure Coding System (HCPCS) codes for emergency visits to part-time dedicated emergency departments (DEDs), referred to by CMS as “Type B” emergency departments. Type B emergency departments are subject to the requirements of the Emergency Medical Treatment and Labor Act (EMTALA) but do not meet the requirements of an emergency department for purposes of Current Procedural Terminology (CPT) codes, and therefore cannot bill under current CPT codes for emergency department visits. According to CMS, the new HCPCS codes will enable CMS to collect appropriate data to determine the related resource costs of these entities. This new payment structure reflects the CMS position that, for part-time DEDs, five payment levels are appropriate rather than having part-time DEDs continue to bill under CPT codes for clinic visits.

The final rule also provides for differential payment to distinguish between critical care provided without trauma activation and critical care provided with trauma activation. A new G-Code has been adopted for trauma activation and response in association with critical care services.

**Final Rule Does Not Adopt New Codes for Full-Time DEDs or for Facility Clinic Visits.** The final rule does not adopt previously proposed new HCPCS codes for hospital clinic visits or for visits to full-time emergency departments meeting all of the requirements of a CPT-defined emergency department, plus certain additional CMS requirements, referred to by CMS as “Type A” emergency departments. These proposed new HCPCS codes will await the issuance of national facility-specific guidelines with respect to each of these areas, including national guidelines for evaluation and management (E&M) services in facility settings.

**Revision of the APC Structure of Drug Administration Services.** The Ambulatory Payment Classification (APC) payment and coding structure for drug administration services is revised to allow hospitals to report the same CPT codes used by physicians and other payers, and to be paid separately for additional hours of infusion. The rule finalizes a six-level drug administration APC structure. CMS anticipates that these revisions will more accurately reimburse hospitals for complex and lengthy drug administration services, while also providing more appropriate payments for individual services.

**Revision of Payments for Drugs and Biologicals.** Separately payable drugs and biologicals (those costing more than \$55 per day) are to be paid at 106% of the average sales price. Radiopharmaceuticals will be paid at a hospital’s charges adjusted to cost using hospital-specific cost-to-charge ratios. Payments for drugs not separately payable (those costing less than \$55 per day) generally will continue to be included within the payments for their related procedures.

**Change to CAH conditions of participation.** CMS revised the conditions of participation for critical access hospitals (CAHs) to allow a registered nurse on site at the CAH as one of the qualified medical personnel available to perform appropriate emergency medical screening examinations.

**Transition in Administration of Hospital Claims for Outpatient Services.** New entities known as Medicare Administrative Contractors (MACs) will take over the administration of hospital claims for outpatient services from fiscal intermediaries and carriers. This transition process will happen over a multi-year period. CMS indicates that providers and suppliers will be assigned to a MAC based on geographic location with certain exceptions.

**Addition of Procedures to the ASC List.** The final rule adds 19 procedures to the list of covered procedures for which Medicare will reimburse ASCs.

**Decreased Payment for Approximately 280 ASC Procedures.** The final rule implements in CY 2007 a provision of the DRA requiring that Medicare payment for surgical procedures performed in ASCs not exceed the Medicare payment for the same procedures when performed in a hospital outpatient department subject to the OPPIs. CMS indicates that decreased payment for about 280 procedures on the ASC list should result.

If you have any questions about these new regulations, please contact any of the attorneys in our Health Law Practice Area listed below.

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