Changing Regulations: A Focused Review of the 2010 OPPS Final Rule

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Executive Summary

Medicare's main objectives, beginning in 2008 and marching forward now to 2010, are to continue with "value-based purchasing" terminology and policies to promote "efficiency incentives." For years, Medicare utilized external data for the OPPS rate setting services; however, as the system has matured and Medicare has collected and analyzed more data, they now rely on the cost data from claims. As in every year, with the release of the final rule, it is essential to secure your SWOT team and incorporate the new changes by January 1, along with dedicated verification of claims submission for first quarter 2010. As internal auditors you will want to verify this has happened, that changes were correctly implemented, and that for the remaining months of the year claims will be accurate with respect to the Final Rule.

Introduction

To successfully analyze Strengths, Weaknesses, Opportunities and Threats (SWOT) you will need to have developed a list with the appropriate team members, which assures your organization designed a formidable execution plan that includes implementation, management, and forecasting APC revenue impact set forth by changes in payment policies. Hospitals should have plotted their strategies for coping with the positive and negative financial impact and operational challenges posed by the OPPS. In doing so, your hospital will have incorporated an "insurance plan" against Recovery Audit Contractors (RAC) initiatives.

You will need to continue to be prepared to react because CMS will publish further coding and billing instructions at a later date. By developing a working team to implement needed changes and to manage the comprehensive 2010 OPPS and CPT updates, you will have ensured your outpatient revenue cycle is APC-ready, RAC compliant, and financially sound. If you find your hospital did not use a *SWOT* approach you may want to consider advising management to begin planning for putting together a work team by the end of summer to be ready to address 2011 changes.

Direct Physician Supervision for 2010

After CMS issued a "restatement and clarification" in the final 2009 OPPS rule, providers continued to raise questions throughout the year. The final 2010 OPPS rule has offered expanded definitions for facilities to implement immediately with participation of their attorney(s), compliance officer, medical staff and clinicians. For calendar years (CY) 2000-2008, CMS will exercise their discretion and decline to enforce those situations involving claims where the hospitals' non-compliance with the direct physician supervision policy resulted from error or mistake. They will not be so forgiving beginning with 2009 and going forward.

Beginning January 1, 2010, CMS will allow expansion of physicians and non-physician practitioners (NPP) who may directly supervise all hospital outpatient therapeutic services that they may perform themselves, within their state's scope of practice and hospital-granted privileges. The NPP expansion includes physician assistants, nurse practitioners, clinical nurse specialists, certified nurse midwives and licensed clinical social workers.

During outpatient therapeutic services, which include chemotherapy and wound care, to name a few, the physician and NPPs must be present in the hospital or the on-campus provider-based department (PBD) of the hospital. Being *immediately available* requires that the physician or NPP must be physically present in areas of the hospital campus that are part of the hospital, including on-campus PBDs operated by the hospital, and where services furnished in those areas are billed under the hospital's CCN (CMS certification number). This also allows the supervising physician and NPPs to be in a non-hospital space on the campus which could make it easier to respond immediately.

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As far as the off-campus PBD goes, the physician or NPP must be present and immediately available to furnish assistance and direction throughout the performance of the procedure. This is consistent with CMS's policy since April 2000.

Immediately available is defined as the physician or NPP must be prepared to step in and perform the service, not just to respond to an emergency. This includes the ability to take over the performance of

the procedure and, as appropriate to both the supervisory physician or NPP and the patient, to change a procedure or the course of treatment being provided to a particular patient, also remembering this must be within his/her state's scope of practice and hospital-granted privileges.

Medicare Improvements for Patients and Providers Act (MIPPA) New Benefit Categories

Effective January 1, 2010, MIPPA expanded coverage in two specific clinical areas: 1) kidney disease education (KDE) for providers located in rural areas or that have been reclassified from urban to rural and pulmonary, and 2) cardiac rehabilitation services for beneficiaries with COPD and other certain conditions. Specific (HCPCS) G-codes have been developed for KDE, intensive cardiac rehabilitation (ICR), and pulmonary rehabilitation (PR) along with specific number of session(s), length, and time period. It is advisable to review the 2010 Final Rule for Payment Policies under Physician Fee Schedule and Other Revisions to Part B for 2010 for further details regarding program approval and documentation requirements.

APC Financial Barometer

Under OPPS, CMS annually updates the financial indicators that include the conversion factor, and co-beneficiary payments and outlier formulas. Since the reimbursement landscape evolves year to year, you must stay on top of these changes.

For hospitals, the outlier formula has been modified this year as follows: 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 $2,175 (as opposed to $1,800 in 2009). The outlier payment remains at 50% of the amount by which the cost is exceeded.

The national conversion factor for 2010 is $67.406. For hospitals that do not meet the outpatient quality reporting requirements; the conversion factor is reduced by 2% or $66.086. The beneficiary co-payment is 40% of APC payment, and the minimum remains 20%. Rural sole community hospitals (SCHs) along with essential access community hospitals (EACHs) will continue to receive a 7.1% payment increase in 2010. For hospitals in rural areas with no more than 100 beds, the transitional pass through payments protection will expire as of January 1, 2010. And yes, the inpatient only list (SI C) is alive and well for 2010 and must be communicated to your physician staff.

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Vigilance is Essential with your Pharmacy CDM

For 2010, Medicare will continue to reimburse detailed payable drugs using Average Sales Price (ASP) + 4% which has integrated payments for both acquisition and overhead costs aggregate. The threshold for packaged drugs was increased to a median cost less than $65. Anti-emetics will now be eligible (beginning in 2010), for the packaging threshold, unlike previous years, where they were exempted. Therapeutic radiopharmaceuticals and brachytherapy sources will now move from the cost-paid system to APC rate methodology to include outlier payments, when applicable.

Status Quo with Facility E/M Levels under OPPS

For 2010 hospitals must continue to preserve and use their internally developed guidelines for ED and Clinic E/M visits, plus adhere to the 11 principles developed in 2008 by CMS.

The new and established facility E/M definition was debated; however, CMS continues to see a stable distribution of E/M visit code date. CMS will continue with 2009's definition whether or not the patient was *registered as an inpatient or outpatient* of the hospital within the past three (3) years. If not, considered new; if so, consider as an established patient.

Other points of interest reiterated by CMS: Critical care services must be dictated by the instructions in the CPT manual to include time requirements. The final rule reiterated that Type A and B ED visits will continue with no changes to the definitions with a new Level V Type B ED APC created.

I strongly advise performing a detailed audit of E/M levels to ensure consistency and accuracy and that the clinic definition of *new* vs. *established* patient is followed correctly. Also, the monitoring of modifier -25, especially for those clinics in which scheduled procedures are performed along with the medical visit on the same day, helps to zero-in on those potential RAC vulnerabilities.

Drug Administration Services…your Favorite and Mine

For 2010, CMS reiterates to providers to use the CPT codes, definitions, and guidelines as listed in the *CPT Manual*.

This was CMS's second opportunity to examine hospitals' 2008 claims data for the full set of CPT codes reflecting concepts for initial, sequential and concurrent services. CMS continues drug administration APCs into five (5) and many CPT codes in this area have been mapped to APC categories with even lower payments.

It is an imperative, and bears repeating, that you need to provide critical feedback to clinicians that these codes are *time-based codes* which require *time-line documentation* in order to support charge capture and APC revenue reimbursement.

Relocation of APC Payments for 2010

Annually and by law, CMS must review APC groups and recalibrate where necessary, especially when the 2X rule is violated. Looking at the commonality of procedures amongst hospitals, some areas of interest to audit from a coding and financial impact perspective for 2010 include: cardiology, digestive, pain management, and orthopedic procedures.

As part of any audit, in conjunction with your finance department, include a financial analysis comparing 2008 to 2009 payments to the appropriate departments. The best way to accomplish this task is to perform an audit of the medical record documentation and claims submissions.

Hospital Outpatient Quality Data Reporting Program

CMS introduced seven outpatient measures in 2008 to tie to future OPPS payments. For 2009, four new measures were added, which include MRI lumbar spine for low back pain; mammography follow-up rates; abdomen CT use of contrast material; and thorax CT use of contrast material. Hospitals that failed to report quality measure data in 2008 will begin to see a 2% reduction in their 2009 conversion factor. This means hospitals will be paid at a lower APC payment rate than those providers who met the quality measure reporting requirements. Beneficiary and secondary-payer payments will also be reduced. Hospitals that are exempt from IPPS are also exempt from these provisions, as are critical access hospitals.

The Returning Composites—Continuing for 2010

CMS introduced the concept of APC composite payments in 2008 and 2009, and this continues for 2010: 8000 Cardiac Electrophysiologic Evaluation and Ablation; 8001 Low Dose Rate (LDR) Prostate Brachytherapy; 8002 Level 1 Extended Assessment and Management; 8003 Level II Extended Assessment and Management; and 0034 Mental Health, plus the Imaging Composites 8004–8008. CMS intends to expand and explore where this payment model may be utilized in the future to further encourage hospital efficiencies: however, CMS does not want to move to quickly until more data becomes available.

> I strongly advise performing a detailed audit of E/M levels.

Summary

Medicare continues to change with the times and even force times to change with the various efficiency incentives. Providers need to respond and even more so to be on their toes to ensure reimbursement for services provided are always accurately billed and paid. Internal audit and compliance professionals have a role to play by ensuring that their organizations consistently comply with change by adapting their staff education and transaction systems to the new requirements.

For the final 2010 OPPS rule, go to http://www.cms.hhs.gov/HospitalOutpatientPPS/

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