

# Washington Bulletin

Health care legislative and regulatory update



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## CMS Releases Final Hospital Outpatient PPS Update and ASC Payment Changes for CY 2011

The Centers for Medicare and Medicaid Services (CMS) have issued a final rule updating the Hospital Outpatient Prospective Payment System (OPPS) and the Ambulatory Surgical Center (ASC) payment system for **Calendar Year (CY) 2011**. **The rule is on display at the *Federal Register* Office and is scheduled for publication on November 24<sup>th</sup>.** A [copy](#) of the 2,452 page document is on the *Federal Register* web site.

The rule provides a market-basket (MB) update of 2.60 percent, for hospitals providing quality data elements and 0.60 percent for those that do not. The updates are reduced by 0.25 percent as mandated by the *Affordable Health Care Act* (ACA) yielding increases of 2.35 and 0.35 percent, respectively.

For ASCs, CY 2011 will be the first year of full payment rates under the revised ASC payment system payment methodology following a four-year transition.

### Significant Changes

CMS has highlighted the following as significant items:

#### OPPS

- **OPPS Market Basket update** – The ACA requires CMS to reduce the HOPD fee schedule increase factor (commonly referred to as the hospital operating market basket increase factor) for CY 2011 OPPS payment by 0.25 percentage point. Therefore, the CY 2011 OPPS payment rates reflect a hospital operating market basket increase factor of 2.35 percent (that is, the estimated hospital operating market basket increase factor of 2.60 percent less the 0.25 percentage point reduction) for hospitals providing quality data information, and 0.35 percent for those not submitting such data.
- **Waiver of beneficiary cost-sharing for preventive services** – The ACA waives the deductible and copayment for certain preventive services that are paid under the OPPS, including the initial preventive physical examination (IPPE) and preventive services that have been recommended by the United States Preventive Services Task Force with a grade of A or B for any indication or population.
- **Payment adjustment for certain cancer hospitals** – The ACA requires CMS to conduct a study to determine if outpatient costs incurred by cancer hospitals that meet the classification criteria set forth in the statute exceed outpatient costs incurred by other hospitals paid under the OPPS and to make an appropriate budget neutral payment adjustment if these cancer hospitals are found to be more costly.

After consideration of comments, CMS says that further study and deliberation is required and will not finalize a payment adjustment, as proposed, for cancer hospitals for CY 2011.

- **Frontier state wage provisions** – For services beginning in CY 2011, the wage adjustment factor applicable to any HOPD that is located in a state in which at least 50 percent of the counties have a population per square mile of less than 6 (excluding Alaska and Hawaii) may not be less than 1.0000. This provision, which the law does not make subject to budget neutrality requirements, will benefit hospitals in the states of Montana, Wyoming, Nevada, North Dakota, and South Dakota without requiring reductions in payments to hospitals located in other states.

- **Quality measures to be reported** – To allow CMS and hospitals to more effectively plan for future quality reporting requirements, CMS has included measures for three subsequent payment determinations in this year's final rule. CMS is adding four quality measures to the current list of 11 measures to be reported by HOPDs, bringing the total number of measures to 15 that are to be reported for purposes of the CY 2012 payment determination. These new measures include one structural health information technology (HIT) measure and three claims-based imaging efficiency measures.

CMS is also adding eight new measures to the list for purposes of the CY 2013 payment determination (for a total of 23 measures). Of these new measures, one is a structural measure on use of electronic health records, and six are chart-abstracted measures of timeliness and appropriate care in the emergency department.

CMS also plans to require the reporting of these 23 measures for the 2014 payment determination.

- **Validation of quality reporting** – In CY 2011 payment determinations, CMS implemented a hospital outpatient quality data reporting program (HOP QDRP) validation requirement to ensure that hospitals are accurately reporting measures using chart-abstracted data; however, the results of the validation will not affect the CY 2011 payment determination for any hospital. For the CY 2012 payment determination, CMS will validate data from 800 randomly selected hospitals, and will randomly select up to 12 cases per quarter for each hospital. CMS will request the corresponding medical records for the cases, perform its own abstraction of the HOP QDRP chart-abstracted measures for the cases, and compare the results with the measures reported by the hospital. Hospitals will have to achieve a minimum 75 percent validation score based on this process to receive the full OPDS update in CY 2012.
- **Supervision requirements for outpatient therapeutic services** – CMS is providing for a limited exception to its general policy which is to require direct supervision for the duration of all outpatient therapeutic services in both hospitals and critical access hospitals (CAHs). CMS will require direct supervision for the initiation of a service followed by general supervision after the initiation period for a limited set of "non-surgical extended duration services," including observation services, effective January 1, 2011. CMS issued instructions to contractors to not enforce the direct supervision requirement in CAHs for CY 2010. CMS is extending through CY 2011 the notice of non-enforcement for CAHs and expanding it to include small rural hospitals with 100 or fewer beds.

CMS also is modifying the definition of direct supervision for all hospital outpatient services to require "immediate availability" without reference to the boundaries of a physical location, and will be establishing through future rulemaking an independent committee and a process to consider on an annual basis industry requests for supervision levels other than direct supervision for certain individual services, and to make recommendations to the agency.

- **Partial hospitalization program (PHP) services, including services provided by CMHCs** – CMS is establishing four separate PHP APC per diem payment rates, two for CMHC PHPs and two for hospital-based PHPs, which are based on each provider type's data (see chart below for the final per diem payment costs). The CMHC payment rates will be phased in over a two year period. In addition, section 1301 of the **Health Care and Education Reconciliation Act of 2010** (HCERA 2010) enacted on March 30, 2010, revised the definition of a CMHC by adding a requirement that the CMHC must provide at least 40 percent of its services to non-Medicare beneficiaries. HCERA further revised the definition of a PHP (provided by either a CMHC or HOPD) to exclude services furnished in a beneficiary's home or an inpatient or residential setting. CMS is also finalizing its proposal to continue the CMHC outlier threshold at 3.4 times the APC payment amount for APC 173, the higher intensity APC, for CY 2011.

APC	Group Title	Median Per Diem Costs
172	Level 1 Partial Hospitalization (3 services) for CMHCs	\$128.25
173	Level II Partial Hospitalization (4 or more services) for CMHCs	\$162.67
175	Level 1 Partial Hospitalization (3 services) for hospital-based PHPs	\$202.71
176	Level II Partial Hospitalization (4 or more services) for hospital-based PHPs	\$235.79

- **Drugs and pharmacy overhead** – For CY 2011, CMS will pay for the acquisition and pharmacy overhead costs of separately payable drugs and biologicals without pass-through status at the average sales price (ASP) plus 5 percent. The payment rate of ASP plus 5 percent is based upon the cost of separately payable drugs and biologicals, calculated from hospital claims and cost reports, with an adjustment for pharmacy overhead costs. This reflects a redistribution of \$200 million of the pharmacy overhead cost currently attributed to packaged drugs and biologicals

#### Ambulatory Surgical Centers

- **ASC Payment Rate updates** – The percentage increase in the Consumer Price Index for All Urban Consumers that updates the ASC conversion factor for CY 2011 is 1.5 percent. However, beginning in CY 2011, the ACA requires the annual update factor for the ASC payment system be reduced by a productivity adjustment, which is 1.3 percent for CY 2011. As a result, CMS is applying a 0.2 percent update to the ASC payment system for CY 2011 (1.5 minus 1.3).
- **Changes to ASC Covered Surgical Procedures and Covered Ancillary Services** – CMS is adding 6 surgical procedures to the list of procedures for which Medicare would pay when performed in an ASC. CMS is also newly designating two procedures as office-based procedures (subject to payment at lesser of the amount paid under the Medicare physician fee schedule practice expenses for providing the same procedure in an office or the payment amount under the standard ASC rate-setting methodology) and updating the list of covered ancillary services to reflect the OPSS update.
- **Waiver of Beneficiary Cost-Sharing for Preventive Services** – The ACA waives the deductible and coinsurance for certain preventive services that are paid under the ASC payment system and have been recommended by the United States Preventive Services Task Force with a grade of A or B.

#### Other

- **Affordable Care Act Provisions Affecting Physician-Owned Hospitals** – The physician self-referral law generally prohibits physicians from referring Medicare and Medicaid beneficiaries to entities with which they or an immediate family member have a financial relationship for certain designated health services, including inpatient and outpatient hospital services. However, the law allows physicians to refer patients to hospitals in which they have an ownership or investment interest if the ownership or investment is in the whole hospital, rather than in a particular department. An exception to the prohibition is also allowed for some rural hospitals.

ACA Section 6001 “narrows access” to the “rural provider” and “whole hospital” exceptions by prohibiting their use by new physician-owned hospitals, and limiting the ability of existing physician-owned hospitals to expand their capacity. Under section 6001, physician-owned hospitals that were converted from ASCs cannot qualify for the revised rural provider and whole hospital exceptions. Additional provisions in section 6001 are aimed at preventing conflicts of interest, ensuring that all ownership and investment interests are bona fide and promoting patient safety. The final rule incorporates these provisions into CMS regulations.

- Implementing ACA's Graduate Medical Education Provisions** – The final rule also implements the direct and indirect graduate medical education (GME/IME) provisions of the ACA. The law requires CMS to identify unused residency slots and redistribute them to certain hospitals with qualified residency programs, with a special emphasis on increasing the number of primary care physicians. The law also requires CMS to redistribute residency slots from certain closed hospitals and hospitals that close down to other teaching hospitals, giving preference to hospitals in the same or a contiguous area as the closed hospital. In addition, the law specifies how hospitals should count hours a resident spends in certain training and research activities, and in patient care activities in a non-provider setting, such as a physician's office.

**Comments**

Once again, the OPPS update is both extensive and complex. Most of the changes involve coding applications.

CMS, to its credit, has provided a clear summary of the actions it has taken in most of the issues being addressed. Nonetheless, the rule seems to grow exponentially each year as much "history" is repeated.

CMS provides the following analysis:

**Impact of Changes for CY 2011 Hospital Outpatient Prospective Payment System**

	Number of Hospitals (1)	APC Recalibration (2)	New Wage Index and Rural Adjustment (3)	Comb (cols 2 & 3) with Basket Update (4)	Frontier Wage Index Adjustment (5)	All Changes (6)
All Facilities *	4,185	0	0	2.3	2.4	2.5
All Hospitals	3,906	0.3	0	2.6	2.7	2.8
(excludes hospitals permanently held harmless and CMHCs)						
Urban Hospitals	2,919	0.3	0	2.7	2.8	2.9
Large Urban (GT 1 Mill.)	1,585	0.3	0.1	2.8	2.8	2.9
Other Urban (Less 1 Mill.)	1,334	0.3	0	2.6	2.8	2.8
Rural Hospitals	987	0	-0.2	2.2	2.4	2.4
Sole Community	397	0	-0.4	2	2.4	2.4
Other Rural	590	0.1	-0.1	2.3	2.4	2.5
Beds (Urban)						
0 -99 Beds	987	0.3	0	2.7	2.8	2.9
100-199 Beds	864	0.2	0.1	2.6	2.7	2.8
200-299 Beds	451	0.4	0	2.7	2.9	2.9
300-499 Beds	421	0.4	0.1	2.8	2.9	2.9
500 + Beds	196	0.3	0	2.6	2.6	2.8

	<b>Number of Hospitals (1)</b>	<b>APC Recalibration (2)</b>	<b>New Wage Index and Rural Adjustment (3)</b>	<b>Comb (cols 2 &amp; 3) with Basket Update (4)</b>	<b>Frontier Wage Index Adjustment (5)</b>	<b>All Changes (6)</b>
<b>Beds (Rural)</b>						
0 -49 Beds	356	-0.5	0	1.9	2.1	2.2
50-100 Beds	375	-0.1	-0.4	1.9	2.1	2.2
101- 149 Beds	149	0	-0.1	2.3	2.5	2.5
150- 199 Beds	62	0.3	-0.1	2.6	3.1	3.1
200 + Beds	45	0.4	-0.3	2.5	2.5	2.5
<b>Volume (Urban)</b>						
LT 5,000 Lines	595	2.2	0.3	4.8	4.8	5.1
5,000 -10,999 Lines	146	0.7	0.3	3.4	3.4	3.6
11,000 - 20,999 Lines	233	0.3	0.1	2.7	2.8	2.9
21,000 - 42,999 Lines	509	0.1	0.1	2.6	2.6	2.7
42,999 - 89,999 Lines	708	0.3	0.1	2.7	2.8	2.8
GT 89,999 Lines	728	0.3	0	2.7	2.8	2.9
<b>Volume (Rural)</b>						
LT 5,000 Lines	73	-1.2	0.3	1.4	3.3	3.6
5,000 -10,999 Lines	79	-0.9	0.2	1.6	1.7	1.9
11,000 - 20,999 Lines	183	-0.6	-0.1	1.6	1.8	1.9
21,000 - 42,999 Lines	314	-0.4	-0.1	1.9	2.1	2.2
GT 42,999 Lines	248	0.1	-0.2	2.2	2.4	2.5
<b>Region (Urban)</b>						
New England	149	0.3	0.1	2.7	2.7	2.8
Middle Atlantic	362	0.3	-0.3	2.4	2.4	2.5
South Atlantic	461	0.4	0	2.7	2.7	2.8
East North Cent.	471	0.3	0.1	2.7	2.7	2.8
East South Cent.	181	0.2	-0.1	2.4	2.4	2.4
West North Cent.	190	0.4	-0.2	2.6	3.3	3.4
West South Cent.	469	0.4	0.2	3	2.9	3.1
Mountain	198	0.2	-0.1	2.5	2.9	3
Pacific	390	0.4	0.5	3.2	3.2	3.4
Puerto Rico	48	-0.5	-0.4	1.4	1.4	1.6

	<b>Number of Hospitals (1)</b>	<b>APC Recalibration (2)</b>	<b>New Wage Index and Rural Adjustment (3)</b>	<b>Comb (cols 2 &amp; 3) with Basket Update (4)</b>	<b>Frontier Wage Index Adjustment (5)</b>	<b>All Changes (6)</b>
<b>Region (Rural)</b>						
New England	26	0.5	0.8	3.7	3.7	3.7
Middle Atlantic	67	0.3	-0.4	2.2	2.2	2.4
South Atlantic	165	0	-0.4	1.9	1.9	2
East North Cent.	127	0.1	-0.6	1.8	1.8	1.9
East South Cent.	176	-0.2	0	2.1	2.1	2.1
West North Cent.	102	0.4	-1	1.8	2.9	2.9
West South Cent.	224	-0.2	0.7	2.8	2.8	2.9
Mountain	70	-0.2	-0.1	2	4	3.9
Pacific	30	-0.2	-0.3	1.8	1.8	1.8
<b>Teaching Status</b>						
Non-Teaching	2,925	0.2	0	2.6	2.7	2.7
Minor	694	0.3	-0.1	2.6	2.8	2.9
Major	287	0.4	0	2.8	2.8	3
<b>DSH Patient Percent</b>						
0	7	2.3	1.2	5.8	5.8	5.8
GT 0 - 0.10	369	0.5	0	2.8	2.9	2.9
0.10 - 0.16	396	0.3	0.2	2.8	2.9	2.9
0.16 - 0.23	738	0.2	-0.1	2.4	2.7	2.7
0.23 - 0.35	1,021	0.3	-0.1	2.6	2.6	2.7
GE 0.35	771	0.4	0.1	2.8	2.8	3
DSH Not Available **	604	-0.7	0.3	1.9	1.9	2
<b>Urban Teaching/DSH</b>						
Teaching & DSH	893	0.4	0	2.7	2.8	2.9
No Teaching/DSH	1,448	0.3	0.1	2.7	2.8	2.8
No Teaching/No DSH	7	2.3	1.2	5.8	5.8	5.8
DSH Not Available**	571	-0.4	0.3	2.3	2.2	2.4
<b>Type Of Ownership</b>						
Voluntary	2,078	0.3	0	2.6	2.7	2.8
Proprietary	1,260	0.3	0.1	2.7	2.8	2.8

	<b>Number of Hospitals (1)</b>	<b>APC Recalibration (2)</b>	<b>New Wage Index and Rural Adjustment (3)</b>	<b>Comb (cols 2 &amp; 3) with Basket Update (4)</b>	<b>Frontier Wage Index Adjustment (5)</b>	<b>All Changes (6)</b>
Government	568	0.3	0	2.7	2.7	2.9
CMHCs	217	-24.1	0.9	-21.1	-21.1	-21.1

Column (1) shows total hospitals.

Column (2) shows the impact of changes resulting from the reclassification of HCPCS codes among APC groups and the recalibration of APC weights based on 2009 hospital claims data.

Column (3) shows the budget neutral impact of updating the wage index by applying the FY 2011 hospital inpatient wage index. CMS did not propose any changes to the rural adjustment.

Column (4) shows the impact of all budget neutrality adjustments and the addition of the 2.35 percent adjusted OPD fee schedule increase factor (2.6 percent market basket reduced by 0.25 percentage point in accordance with the ACA).

Column (5) shows the non-budget neutral impact of applying the frontier adjustment after application of the adjusted OPD fee schedule increase factor.

Column (6) shows the additional adjustments to the conversion factor resulting from a change in the pass-through estimate and adds outlier payments. This column also shows the expiration of section 508 wages on September 30, 2010 and the application of the Frontier wage adjustment for CY 2011.

\*These 4,185 providers include children and cancer hospitals, which are held harmless to pre-BBA payments, and CMHCs.

\*\* Complete DSH numbers are not available for providers that are not paid under IPPS, including rehabilitation, psychiatric, and long-term care hospitals.

*The discussion below follows the rule's order and is not reflective of major versus minor changes.*

## **UPDATES AFFECTING OPPTS PAYMENTS**

### **Recalibration of APC Relative Weights**

#### **1. Database**

For the purpose of recalibrating the APC relative payment weights for CY 2011, CMS says it used approximately 145 million final action claims from hospital outpatient department services furnished on or after January 1, 2009, and before January 1, 2010.

The final APC relative weights and payments for CY 2011 are listed in Addenda A and B.

#### **2. Calculation of Cost-to-Charge Ratios (CCRs)**

For CY 2011, CMS continues using the hospital-specific overall ancillary and departmental CCRs to convert charges on the claims reported under specific revenue codes to estimated costs through application of a revenue code-to-cost center crosswalk.

### **Calculation of Single Procedure APC Criteria-Based Median Costs**

### **1. Device-Dependent APCs**

The CY 2011 OPPS payment rates for device-dependent APCs are based on their median costs calculated from CY 2009 claims and the most recent cost report data, using only single procedure claims that pass the procedure-to-device and device-to-procedure edits, do not contain token charges for devices, do not have an “FB” modifier signifying that the device was furnished without cost or with full credit, and do not contain an “FC” modifier signifying that the hospital received partial credit for the device.

CMS says it continues to believe that the median costs calculated from the single claims that meet these criteria represent the most valid estimated relative costs of these services to hospitals when they incur the full cost of the devices required to perform the procedures.

The rule’s Table 4 lists the APCs for which CMS used its standard device-dependent APC rate setting methodology for CY 2011. CMS notes that it is adding two new device dependent APCs for CY 2011 to Table 4 APC 0318 (Implantation of Cranial Neurostimulator Pulse Generator and Electrode) and APC 0319 (Endovascular Revascularization of the Lower Extremity) APCs. CMS is also deleting APC 0225 from Table 4 because it is replaced with APC 0318 for CY 2011. CMS refers readers to Addendum A for the final payment rates for these APCs.

### **2. Blood and Blood Products**

CMS is finalizing, without modification, its CY 2011 proposal to calculate median costs upon which the CY 2011 payments rates for blood and blood products are based using its blood-specific CCR methodology, which utilizes actual or simulated CCRs from the most recently available hospital cost reports to convert hospital charges for blood and blood products to costs (the methodology the agency has utilized since CY 2005).

CMS refers readers to Addendum B for the final CY 2011 payment rates for blood and blood products, which are identified with status indicator “R.”

### **3. Single Allergy Tests**

CMS proposed to continue differentiating single allergy tests (“per test”) from multiple allergy tests (“per visit”) by assigning these services to two different APCs. Multiple allergy tests are currently assigned to APC 0370 (Allergy Tests).

CMS is finalizing its CY 2011 proposal, without modification, to calculate a “per unit” median cost for APC 0381. The final CY 2011 median cost of APC 0381 is approximately \$33.

### **4. Hyperbaric Oxygen Therapy (HBOT) (APC 0659)**

CMS is finalizing its CY 2011 proposal, without modification for calculating the median cost of APC 0659 for payment of HBOT, with a final CY 2011 median cost of approximately \$150.

### **5. Payment for Ancillary Outpatient Services When Patient Expires (APC 0375)**

CMS is finalizing its CY 2011 proposal, without modification, to continue to use its established rate setting methodology for calculating the median cost of APC 0375, which has a final CY 2011 APC median cost of approximately \$6,304.

### **6. Pulmonary Rehabilitation (PR)**

CMS is finalizing its proposal, without modification, to establish a median cost for APC 0102 by using claims with one unit of HCPCS code G0239, and one unit of HCPCS code G0237 or G0238, and including all costs of the related tests and assessment services (CPT codes 94620, 94664, and 94667 and all the costs of all CPT codes for established patient clinic visits reported on the same date), which results in a final CY 2011 median cost for HCPCS code G0424 of approximately \$62.

### **(7) Endovascular Revascularization of the Lower Extremity (APCs 0083, 0229, and 0319)**

For CY 2011, the AMA's CPT Editorial Panel created 16 new CPT codes in the Endovascular Revascularization section of the 2011 CPT Code Book to describe endovascular revascularization procedures of the lower extremity performed for occlusive disease. The rule's Table 6 lists the 16 new CPT codes that will be effective January 1, 2011.

Of the 16 new codes, CMS assigned nine CPT codes to APC 0083, five to APC 0229, and created a new APC for two CPT codes. Specifically, CMS assigned CPT codes 37220, 37221, 37222, 37223, 37224, 37228, 37232, 37234, and 37235 to APC 0083, which has a final CY 2011 APC median cost of approximately \$3,740. In addition, CMS assigned CPT codes 37225, 37226, 37229, 37230, and 37233 to APC 0229, which has a final CY 2011 APC median cost of approximately \$7,940. Because the resource costs associated with CPT codes 37227 and 37231 are not similar to the costs of procedures in the existing APCs, CMS established a new APC, specifically APC 0319 (Endovascular Revascularization of the Lower Extremity), which has a final CY 2011 APC median cost of approximately \$13,751 to pay for these services.

The new CY 2011 endovascular revascularization CPT codes and their final CY 2011 APC assignments and APC median costs are displayed in the table below.

**Final CY 2011 APC Assignments and Median Costs for the Endovascular Revascularization CPT Codes**

CY 2011 CPT Code	CY 2011 Long Descriptor	Final CY 2011 APC	Final CY 2011 CPT Median Cost
37220	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty	83	\$5,080
37221	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	83	\$6,710
37222	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)	83	N/A
37223	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s) (List separately in addition to code for primary procedure), includes angioplasty within the same vessel, when performed	83	N/A
37224	Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with transluminal angioplasty	83	\$5,247
37225	Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed	229	\$9,023
37226	Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	229	\$9,600
37227	Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes	319	\$13,754

<b>CY 2011 CPT Code</b>	<b>CY 2011 Long Descriptor</b>	<b>Final CY 2011 APC</b>	<b>Final CY 2011 CPT Median Cost</b>
	angioplasty within the same vessel, when performed		
37228	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with transluminal angioplasty	83	\$5,563
37229	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed	229	\$9,231
37230	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) , includes angioplasty within the same vessel, when performed	229	\$7,868
37231	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	319	\$13,604
37232	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)	83	9,412
37233	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy (List separately in addition to code for primary procedure), includes angioplasty within the same vessel, when performed	229	\$10,183
37234	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) (List separately in addition to code for primary procedure), includes angioplasty within the same vessel, when performed	83	N/A
37235	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy (List separately in addition to code for primary procedure), includes angioplasty within the same vessel, when performed	83	N/A

***(8) Non-Congenital Cardiac Catheterization (APC 0080)***

For CY 2011, the AMA CPT Editorial Panel deleted 19 non-congenital cardiac catheterization-related CPT codes and replaced them with 20 new CPT codes in the Cardiac Catheterization and Injection-Related section of the 2011 CPT Code Book to describe more precisely the specific services provided during cardiac catheterization procedures. In particular, the CPT Editorial Panel deleted 19 non-congenital cardiac catheterization-related CPT codes from the 93500 series and created 14 new CPT codes in the 93400 series and 6 in the 93500 series.

The rule's Table 9 lists the specific CPT codes that will be deleted December 31, 2010, and Table 10 lists the new CPT codes that will be effective January 1, 2011.

***(9) Cranial Neurostimulator and Electrodes (APC 0318)***

For CY 2011, the AMA CPT Editorial Panel created a new CPT code 64568 (Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode the combinations of (1) CPT code 64573 (Incision for implantation of neurostimulator electrodes; cranial nerve) and CPT code 61885 (Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array); or (2) CPT code 64573 and CPT code 61886 (Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to two or more electrode arrays).

CMS is creating new APC 0318 (Implantation of Cranial Neurostimulator Pulse Generator and Electrode) for CY 2011, to which CPT code 64568 is the only procedure assigned. APC 0225 (Implantation of Neurostimulator Electrodes, Cranial Nerve), which contained only the predecessor CPT code 64573, is deleted effective January 1, 2011.

#### ***(10) Cardiac and Intensive Cardiac Rehabilitation (APC 0095)***

CMS is establishing \$68.08 as the median cost for APC 0095 for CR and ICR services.

#### **Calculation of Composite APC Criteria-Based Median Costs**

CMS is finalizing, without modification, its proposal to continue its established composite APC policies for extended assessment and management, LDR prostate brachytherapy, cardiac electrophysiologic evaluation and ablation, mental health services, and multiple imaging services.

#### ***(1) Extended Assessment and Management Composite APCs (APCs 8002 and 8003)***

The final CY 2011 median cost for APC 8002 is approximately \$390. The final CY 2011 median cost for composite APC 8003 is approximately \$707

#### ***(2) Low Dose Rate (LDR) Prostate Brachytherapy Composite APC (APC 8001)***

The CY 2011 median cost of APC 8001 is approximately \$3,195.

#### ***(3) Cardiac Electrophysiologic Evaluation and Ablation Composite APC (APC 8000)***

The final CY 2011 median cost is approximately \$10,673 for composite APC 8000.

#### ***(4) Multiple Imaging Composite APCs (APCs 8004, 8005, 8006, 8007, and 8008)***

CMS is adopting its CY 2011 proposal, without modification, to continue paying for all multiple imaging procedures within an imaging family performed on the same date of service using the multiple imaging composite payment methodology.

#### **Changes to Packaged Services**

CMS notes that in aggregate, its analysis showed that hospitals do not appear to have significantly changed their reporting patterns as a result of the expanded packaging policy nor do the analyses suggest that hospitals have stopped offering these supporting and ancillary services with the primary diagnostic and therapeutic modalities that they support.

CMS will pay separately for the placement of CPT code 19295 (Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)) when it is not reported on a claim with any other separately paid procedure with a status indicator of "S," "T," "V," or "X." CMS has assigned CPT code 19295 to APC 0340 (Minor Ancillary Procedures), for which the median cost for CY 2011 is \$48.72.

#### **Conversion Factor (CF) Update**

CMS announced the CY 2010 OPPS conversion factor of \$67.241 in an OPPS/ASC notice (CMS 1504-N), issued in the **Federal Register** on August 3, 2010. This amount reflects the changes required by the ACA retroactive to January 1, 2010.

Hospitals that fail to meet the reporting requirements of the Hospital Outpatient Quality Data Reporting Program (HOP QDRP) are subject to a reduction of 2.0 percentage points from the OPD fee schedule increase factor adjustment to the CF.

To set the OPPS conversion factor for CY 2011, CMS first increased the CY 2010 conversion factor of \$67.241 by 2.35 percent.

CMS calculated an overall budget neutrality factor of 1.0009 for wage index changes. CMS is not making a change to its rural adjustment policy. CMS estimated that pass-through spending for both drugs and biologicals and devices for CY 2011 would equal approximately \$57.7 million, which represents 0.15 percent of total projected CY 2011 OPPS spending. Therefore, the conversion factor was also adjusted by the difference between the 0.14 percent estimate of pass-through spending for CY 2010 and the 0.15 percent estimate of CY 2011 pass-through spending. Finally, estimated payments for outliers remain at 1.0 percent of total OPPS payments for CY 2011.

This results in a conversion factor for CY 2011 of **\$68.876**. For those hospitals that fail to meet the requirements of the HOP QDRP for the full CY 2011 payment update, the reduced conversion factor for CY 2011 is \$67.530 (a difference of -\$1.346).

### **Wage Index Changes**

CMS is finalizing its CY 2011 proposal, without modification, to use the final FY 2011 IPPS wage indices to adjust the OPPS standard payment amounts for labor market differences. The labor portion remains at 60 percent.

The ACA created a "Frontier state" adjustment. CMS is referencing this item, referring readers to the IPPS material and states it has made necessary changes to the regulations. The frontier state wage index is the greater of 1.000 or the area's value.

### **Statewide Average Default CCRs**

CMS is finalizing its proposal to apply the agency's standard methodology of calculating the statewide average default CCRs using the same hospital overall CCRs that CMS used to adjust charges to costs on claims data. The rule's Table 15 contains the statewide average default CCRs.

### **OPPS Payment to Certain Rural and Other Hospitals**

#### ***1. Hold Harmless Transitional Payment Changes (TOPs)***

Effective for services provided on or after January 1, 2011, rural hospitals having 100 or fewer beds that are not Sole Community Hospitals (SCHs) and SCHs, including Essential Access Care Hospitals (EACHs) will no longer be eligible for hold harmless TOPs, in accordance with section 3121 of the ACA.

#### ***2. Adjustment for Rural SCHs Implemented in CY 2006***

CMS is finalizing its CY 2011 proposal, without modification, to apply the 7.1 percent payment adjustment to rural SCHs, including EACHs, for all services and procedures paid under the OPPS in CY 2011, excluding separately payable drugs and biologicals, devices paid under the pass-through payment policy, and items paid at charges reduced to costs.

## OPPS Payments to Cancer Hospitals

There are 11 cancer hospitals that are exempted from payment under the inpatient prospective payment system (IPPS). Since the inception of the hospital OPPS, Medicare has paid cancer hospitals under the OPPS for covered outpatient hospital services.

The ACA instructs the Secretary to conduct a study to determine if, under the OPPS, outpatient costs incurred by cancer hospitals exceed the costs incurred by other hospitals furnishing services.

CMS is not finalizing, as proposed, an adjustment for certain cancer hospitals identified in section 1886(d)(1)(B)(v) of the Act at this time.

## Hospital Outpatient Outlier Payment

For CY 2011, CMS will continue to make an outlier payment that equals 50 percent of the amount by which the cost of furnishing the service exceeds 1.75 times the APC payment amount when both the 1.75 multiple threshold and the final fixed-dollar \$2,025 threshold are met.

For CMHCs, if a CMHC's cost for partial hospitalization services, paid under either APC 0172 or APC 0173, exceeds 3.40 times the payment for APC 0173, the outlier payment is calculated as 50 percent of the amount by which the cost exceeds 3.40 times the APC 0173 payment rate. CMS estimates that this threshold will allocate 0.02 percent of outlier payments to CMHCs for PHP outlier payments.

## OPPS AMBULATORY PAYMENT CLASSIFICATION (APC) GROUP POLICIES

### A. OPPS Treatment of New HCPCS and CPT Codes

CPT and HCPCS code changes that affect the OPPS are published both through the annual rulemaking cycle and through the OPPS quarterly update Change Requests (CRs).

CMS recognizes the following codes on OPPS claims: (1) Category I CPT codes, which describe medical services and procedures; (2) Category III CPT codes, which describe new and emerging technologies, services, and procedures; and (3) Level II HCPCS codes, which are used primarily to identify products, supplies, temporary procedures, and services not described by CPT codes.

#### ***1. Treatment of New Level II HCPCS Codes and Category I CPT Vaccine Codes and Category III CPT Codes for which CMS Solicited Public Comments in the CY 2011 Proposed Rule***

CMS is adopting as final for CY 2011, without modification, to assign the Level II HCPCS codes listed in the table below.

#### **Level II HCPCS Codes with a Change in OPPS Status Indicator or Newly Implemented in April 2010**

CY 2011 HCPCS Code	CY 2010 HCPCS Code	CY 2011 Long Descriptor	Final CY 2011 Status Indicator	Final CY 2011 APC
J3095	C9258	Injection, telavancin, 10 mg	G	9258
J9307	C9259	Injection, pralatrexate, 1 mg	G	9259
J9302	C9260	Injection, of atumumab, 10 mg	G	9260
J3357	C9261	Injection, ustekinumab, 1 mg	G	9261
J8562	C9262	Fludarabine phosphate, oral, 10 mg	G	1339

CY 2011 HCPCS Code	CY 2010 HCPCS Code	CY 2011 Long Descriptor	Final CY 2011 Status Indicator	Final CY 2011 APC
J1290	C9263	Injection, ecallantide, 1 mg	G	9263
G0432	G0432	Infectious agent antibody detection by enzyme immunoassay (EIA) technique, qualitative or semi quantitative, multiple-step method, HIV-1 or HIV-2, screening	A	NA
G0433	G0433	Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, antibody, HIV-1 or HIV-2, screening	A	NA
G0435	G0435	Infectious agent detection by rapid antibody test of oral mucosa transudate, HIV-1 or HIV-2, screening	A	NA
G9143	G9143	Warfarin responsiveness testing by genetic technique using any method, any number of specimen(s)	A	NA
G9147	G9147	Outpatient Intravenous Insulin Treatment (OIVIT) either pulsatile or continuous, by any means, guided by the results of measurements for: respiratory quotient; and/or, urine urea nitrogen (UUN); and/or, arterial, venous or capillary glucose; and/or potassium concentration	E	NA

\*Level II HCPCS code C9262 was deleted June 30, 2010, and replaced with HCPCS code Q2025 effective July 1, 2010. Level II HCPCS code Q2025 will be deleted on December 31, 2010, and replaced with HCPCS code J8562 effective January 1, 2011.

CMS is adopting as final, without modification, to assign the Level II HCPCS codes listed in the table below to the APCs and status indicators as proposed for CY 2011.

### New Level II HCPCS Codes Implemented in July 2010

CY 2011 HCPCS Code	CY 2010 HCPCS Code	CY 2011 Long Descriptor	Final CY 2011 Status Indicator	Final CY 2011 APC
J3262	C9264	Injection, tocilizumab, 1 mg	G	9264
J9315	C9265	Injection, romidepsin, 1 mg	G	9265
J0775	C9266	Injection, collagenase clostridium histolyticum, 0.01 mg	G	1340
J7184	C9267	Injection, von Willebrand factor complex (human), Wilate, per 100 IU VWF: RCO	G	9267
J7335	C9268	Capsaicin 8% patch, per 10 square centimeters	G	9268
C9367	C9367	Skin substitute, Endoform Dermal Template, per square centimeter	G	9367
C9800	C9800	Dermal injection procedure(s) for facial lipodystrophy syndrome (LDS) and provision of Radiesse or Sculptra dermal filler, including all items	T	135

CY 2011 HCPCS Code	CY 2010 HCPCS Code	CY 2011 Long Descriptor	Final CY 2011 Status Indicator	Final CY 2011 APC
		and supplies		
G0428	G0428	Collagen meniscus implant procedure for filling meniscal defects (e.g., CMI, collagen scaffold, Menaflex)	E	NA
G0429	G0429	Dermal filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (e.g., as a result of highly active antiretroviral therapy)	B	NA
J8562	Q2025	Fludarabine phosphate oral, 10 mg	G	1339
Q2026	Q2026	Injection, Radiesse, 0.1 ml	B	NA
Q2027	Q2027	Injection, Sculptra, 0.1 ml	B	NA

The table below lists the Category I CPT vaccine and Category III CPT codes that were implemented in July 2010 for which CMS is allowing separate payment, along with their status indicators, APC assignments, and payment rates for CY 2011.

**Category I Vaccine and Category III CPT Codes Implemented in July 2010**

CY 2011 CPT Code	CY 2011 Long Descriptor	Final CY 2011 Status Indicator	Final CY 2011 APC
0223T	Acoustic cardiography, including automated analysis of combined acoustic and electrical intervals; single, with interpretation and report	S	99
0224T	Multiple, including serial trended analysis and limited reprogramming of device parameter - AV or VV delays only, with interpretation and report	S	690
0225T	Multiple, including serial trended analysis and limited reprogramming of device parameter - AV and VV delays, with interpretation and report	S	690
0226T	Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); diagnostic, including collection of specimen(s) by brushing or washing when performed	X	340
0227T	Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); with biopsy(ies)	T	146
0228T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; single level	T	207
0229T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; each additional level (List separately in addition to code for primary procedure)	T	206
0230T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; single level	T	207
0231T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; each additional level (List separately in addition to code for primary procedure)	T	206

CY 2011 CPT Code	CY 2011 Long Descriptor	Final CY 2011 Status Indicator	Final CY 2011 APC
0232T	Injection(s), platelet rich plasma, any tissue, including image guidance, harvesting and preparation when performed	X	340
0233T	Skin advanced glycation endproducts (AGE) measurement by multi-wavelength fluorescent spectroscopy	A	NA
90664	Influenza virus vaccine, pandemic formulation, live, for intranasal use	E	NA
90666	Influenza virus vaccine, pandemic formulation, split virus, preservative free, for intramuscular use	E	NA
90667	Influenza virus vaccine, pandemic formulation, split virus, adjuvanted, for intramuscular use	E	NA
90668	Influenza virus vaccine, pandemic formulation, split virus, for intramuscular use	E	NA

**2. Process for New Level II HCPCS Codes and Category I and Category III CPT Codes for which CMS is Soliciting Public Comments on this CY 2011 OPPTS/ASC Final Rule with Comment Period**

CMS is finalizing its policy to include in Addendum B to the CY 2011 OPPTS/ASC final rule new Category I and III CPT codes effective January 1, 2011 (including those Category I vaccine and Category III CPT codes that were released by the AMA in July 2010) that would be incorporated in the January 2011 OPPTS quarterly update Change Request (CR) and the new Level II HCPCS codes, effective October 1, 2010, or January 1, 2011, that would be released by CMS in its October 2010 and January 2011 OPPTS quarterly update CRs.

**3. Temporary HCPCS Codes for 2010-2011 Seasonal Influenza Vaccines**

Medicare has established five HCPCS Q-codes to identify the individual influenza products that are reported with CPT code 90658. The specific list of HCPCS Q-codes can be found in in the table below

**Influenza HCPCSs Q-Codes for CY 2011**

HCPCS Code	Short Descriptor	Long Descriptor	Final CY 2011 SI
90658	Flu vaccine, 3 yrs & >, im	Influenza virus vaccine, split virus, when administered to 3 years of age and older, for intramuscular use	E
Q2035	Afluria vacc, 3 yrs & >, im	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (afluria)	L
Q2036	Flulaval vacc, 3 yrs & >, im	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (flulaval)	L
Q2037	Fluvirin vacc, 3 yrs & >, im	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (fluvirin)	L
Q2038	Fluzone vacc, 3 yrs & >, im	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (fluzone)	L
Q2039	NOS flu vacc, 3 yrs & >, im	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (not otherwise specified)	L

CMS says that hospitals are advised to report the influenza HCPCS Q-codes rather than CPT code 90658 for CY 2011. These codes have been included in the HCPCS file with an added date of January 1, 2011, but the HCPCS codes will be implemented effective October 1, 2010.

### B. OPPS Changes – Variations within APCs

The following table identifies 22 APCs that CMS would exempt from the APC two times rule.

CY 2011 APC	CY 2011 APC Title
57	Bunion Procedures
58	Level I Strapping and Cast Application
60	Manipulation Therapy
76	Level I Endoscopy Lower Airway
80	Diagnostic Cardiac Catheterization
83	Coronary and Noncoronary Angioplasty and Percutaneous Valvuloplasty
105	Repair/Revision/Removal of Pacemakers, AICDs, or Vascular Devices
133	Level I Skin Repair
142	Small Intestine Endoscopy
203	Level IV Nerve Injections
235	Level I Posterior Segment Eye Procedures
245	Level I Cataract Procedures without IOL Insert
303	Treatment Device Construction
304	Level I Therapeutic Radiation Treatment Preparation
340	Minor Ancillary Procedures
341	Skin Tests
343	Level III Pathology
432	Health and Behavior Services
433	Level II Pathology
604	Level 1 Hospital Clinic Visits
607	Level 4 Hospital Clinic Visits
664	Level I Proton Beam Radiation Therapy

### C. New Technology APCs

CMS says that there are currently 82 New Technology APCs, ranging from the lowest cost band assigned to APC 1491 (New Technology – Level IA (\$0-\$10)) through the highest cost band assigned to APC 1574 (New Technology – Level XXXVII (\$9,500-\$10,000)).

CMS is finalizing, without modification, to assign HCPCS code G0416 to APC 0616, which has a final CY 2011 APC median cost of approximately \$149, and to assign HCPCS code G0417 to APC 1506, which has a final CY 2011 APC median cost of approximately \$489.

#### **D. OPPS APC-Specific Policies**

**Comment** – CMS discusses numerous assignments of codes and APCs. Most continue existing assignments. Reported below are those CMS says it has proposed changes.

##### ***a. Myocardial Positron Emission Tomography (PET) Imaging (APC 0307)***

CMS proposed to assign CPT codes 78459 (Myocardial imaging, positron emission tomography (PET), metabolic evaluation), 78491 (Myocardial imaging, positron emission tomography (PET), perfusion; single study at rest or stress), and 78492 (Myocardial imaging, positron emission tomography (PET), perfusion; multiple studies at rest and/or stress) to APC 0307 (Myocardial Position Emission).

CMS is finalizing a payment rate for APC 0307 for CY 2011 based on the CY 2011 OPPS final rule median cost of approximately \$1,096.

##### ***b. Gastrointestinal (GI) Services: Upper GI Endoscopy (APCs 0141, 0384, and 0422)***

For CY 2011, CMS proposed to reassign four upper gastrointestinal endoscopy CPT codes from APC 0141 (Level I Upper GI Procedures) to APC 0422 (Level II Upper GI Procedures).

CMS is finalizing, without modification, to reassign CPT codes 43216, 43242, 43510, and 43870 from APC 0141 to APC 0422, which has a final CY 2011 APC median cost of approximately \$1,137. CMS also is finalizing, without modification, to continue to assign CPT code 43240 to APC 0141, which has a final CY 2011 APC median cost of approximately \$605, and to continue to assign CPT code 43228 to APC 0422, which has a final CY 2011 APC median cost of approximately \$1,137.

##### ***c. Nervous System Services – Pain-Related Procedures (APCs 0203, 0204, 0206, 0207, and 0388)***

For CY 2011, CMS proposed to set the payment rates for APCs to which pain-related procedures were assigned based on the median costs determined under the standard OPPS rate setting methodology. Specifically, CMS proposed the following CY 2011 payment rates for the pain-related APCs: APC 0203 (Level IV Nerve Injections), with a proposed payment rate of approximately \$908; APC 0204 (Level I Nerve Injections), with a proposed payment rate of approximately \$182; APC 0206 (Level II Nerve Injections), with a proposed payment rate of approximately \$265; APC 0207 (Level III Nerve Injections), with a proposed payment rate of approximately \$527, and APC 0388 (Discography), with a proposed payment rate of approximately \$1,702).

For CY 2011, CMS proposed to reassign CPT codes 62273 (Injection, epidural, of blood or clot patch) and 64408 (Injection, anesthetic agent; vagus nerve) from APC 0206 to APC 0207, and to reassign CPT code 62319 (Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)) from APC 0207 to APC 0203.

CMS is finalizing the APC assignments for all of these procedures as shown in the table below.

**Pain-Related Procedures on Which CMS Received Public Comments**

<b>CPT Code</b>	<b>Long Descriptor</b>	<b>CY 2010 APC</b>	<b>Proposed CY 2011 APC</b>	<b>Final CY 2011 APC</b>
62273	Injection, epidural, of blood or clot patch), 64408 (Injection, anesthetic agent; vagus nerve	206	207	207
62318	Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic	207	207	207
62319	Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)	207	203	203
64408	Injection, anesthetic agent; vagus nerve	207	207	207
64410	Injection, anesthetic agent; phrenic nerve	207	207	207
64412	Injection, anesthetic agent; spinal accessory nerve	207	207	207
64480	Injection, anesthetic agent and/or steroid, transforaminal epidural; cervical or thoracic, each additional level (List separately in addition to code for primary procedure)	206	206	206
64484	Injection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, each additional level (List separately in addition to code for primary procedure)	206	206	206
64491	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)	204	204	204
64492	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure)	204	204	204
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level	207	207	207
64494	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure)	204	204	204
64623	Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, each additional level (List separately in addition to code for primary procedure)	207	207	207
64626	Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, single level	207	207	207
64627	Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, each additional level (List separately in addition to code for primary procedure)	204	204	204

<b>CPT Code</b>	<b>Long Descriptor</b>	<b>CY 2010 APC</b>	<b>Proposed CY 2011 APC</b>	<b>Final CY 2011 APC</b>
72285	Discography, cervical or thoracic, radiological supervision and interpretation	338	338	338
72295	Discography, lumbar, radiological supervision and interpretation	338	338	338

***d. Device Construction for Intensity Modulated Radiation Therapy (APC 0303)***

CMS is reassigning CPT code 77338 from APC 0303 to APC 0310 for CY 2011.

***e. High Dose Rate Brachytherapy (APC 0313)***

CMS proposed to include four CPT codes in APC 0313 (Brachytherapy). Specifically, APC 0313 would contain CPT codes 77785 (Remote after loading high dose rate radionuclide brachytherapy; 1 channel), 77786 (Remote after loading high dose rate radionuclide brachytherapy; 2-12 channels), 77787 (Remote after loading high dose rate radionuclide brachytherapy; over 12 channels), and 0182T (High dose rate electronic brachytherapy, per fraction).

CMS will base the APC 0313 payment rate on its CY 2011 final rule median cost, which is approximately \$693.

***f. Tumor Imaging (APC 0406 and 0414)***

CMS is retaining CPT codes 78805 and 78806 in APC 0414; and is assigning CPT code 78807 to APC 0414 (instead of APC 0406 as proposed); and is basing the payment for APC 0414 on the CY 2011 final rule median cost of approximately \$470.

***g. Insertion of Anterior Segment Aqueous Drainage Device (APCs 0234, 0255, and 0673)***

CMS is modifying its proposal and reassigning CPT code 0191T to APC 0673 for CY 2011. CMS will continue to monitor claims and cost report data for CPT code 0191T in APC 0673.

**OPPS PAYMENT FOR DEVICES**

***1. Expiration of Transitional Pass-Through Payments for Certain Devices***

There currently is one new device category eligible for pass-through payment, described by HCPCS code C1749 (Endoscope, retrograde imaging/illumination colonoscope device (implantable), which CMS announced in the October 2010 OPPS Update (Transmittal 2050, Change Request 7117, dated September 17, 2010). There are no categories for which CMS proposed expiration of pass-through status in CY 2011.

***2. Provisions for Reducing Transitional Pass-Through Payments to Offset Costs Packaged into APC Groups***

CMS is finalizing, without modification, to continue the policy to specify that the pass-through evaluation process and pass-through payment methodology for implantable biologicals that are surgically inserted or implanted (through a surgical incision or a natural orifice) and that are newly approved for pass-through status on or after January 1, 2010, be the device pass-through process and payment methodology only.

CMS also is finalizing, other proposals, without modification, to continue the following policies regarding device offsets: (1) including implantable biologicals in calculating the device APC offset amounts; (2) using the device APC offset amounts to evaluate whether the cost of a device (defined to include implantable biologicals) in an application for a new device category for pass-through payment is not insignificant in relation to the APC payment amount for the service related to the category of devices; and (3) reducing device pass through

payments based on device costs already included in the associated procedural APCs, when CMS determines that device costs associated with the new category are already packaged into the existing APC structure.

**3. Adjustment to OPPS Payment for Partial or Full Credit Devices**

CMS is finalizing, without modification, to continue the established no cost/full credit and partial credit adjustment policy. The first table below lists the APCs to which the payment adjustment policy for no cost/full credit and partial credit devices will apply in CY 2011 and displays the final payment adjustment percentages for both no cost/full credit and partial credit circumstances.

The second table lists the devices to which no cost/full credit and partial credit device adjustment policy will apply for CY 2011.

**APCs to Which the No Cost/Full Credit and Partial Credit Device Adjustment Policy Will Apply**

Final CY 2011 APC	CY 2011 APC Title	Final CY 2011 Device Offset Percentage for No Cost/ Full Credit Case	Final CY 2011 Device Offset Percentage for Partial Credit Case
39	Level I Implantation of Neurostimulator Generator	86%	43%
40	Percutaneous Implantation of Neurostimulator Electrodes	58%	29%
61	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electrodes	64%	32%
89	Insertion/Replacement of Permanent Pacemaker and Electrodes	71%	35%
90	Insertion/Replacement of Pacemaker Pulse Generator	73%	36%
106	Insertion/Replacement of Pacemaker Leads and/or Electrodes	46%	23%
107	Insertion of Cardioverter-Defibrillator	88%	44%
108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	87%	44%
227	Implantation of Drug Infusion Device	81%	41%
259	Level VII ENT Procedures	85%	43%
315	Level II Implantation of Neurostimulator Generator	88%	44%
318	Implantation of Cranial Neurostimulator Pulse Generator and Electrode	85%	43%
385	Level I Prosthetic Urological Procedures	61%	31%
386	Level II Prosthetic Urological Procedures	71%	36%
418	Insertion of Left Ventricular Pacing Elect.	73%	36%
425	Level II Arthroplasty or Implantation with Prosthesis	59%	30%
648	Level IV Breast Surgery	46%	23%
654	Insertion/Replacement of a permanent dual chamber pacemaker	74%	37%
655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker	74%	37%
680	Insertion of Patient Activated Event Recorders	71%	35%

**Devices to Which the No Cost/Full Credit and Partial Credit Device Adjustment Policy Will Apply**

<b>CY 2011 Device HCPCS Code</b>	<b>CY 2011 Short Descriptor</b>
C1721	AICD, dual chamber
C1722	AICD, single chamber
C1728	Cath, brachytx seed adm
C1764	Event recorder, cardiac
C1767	Generator, neurostim, imp
C1771	Rep dev, urinary, w/sling
C1772	Infusion pump, programmable
C1776	Joint device (implantable)
C1777	Lead, AICD, endo single coil
C1778	Lead, neurostimulator
C1779	Lead, pmkr, transvenous VDD
C1785	Pmkr, dual, rate- resp
C1786	Pmkr, single, rate- resp
C1789	Prosthesis, breast, imp
C1813	Prosthesis, penile, inflatab
C1815	Pros, urinary sph, imp
C1820	Generator, neuro rechg bat sys
C1881	Dialysis access system
C1882	AICD, other than sing/ dual
C1891	Infusion pump, non-prog, perm
C1895	Lead, AICD, endo dual coil
C1896	Lead, AICD, non sing/ dual
C1897	Lead, neurostim, test kit
C1898	Lead, pmkr, other than trans
C1899	Lead, pmkr/AICD combination
C1900	Lead coronary venous
C2619	Pmkr, dual, non rate- resp
C2620	Pmkr, single, non rate- resp
C2621	Pmkr, other than sing/ dual
C2622	Prosthesis, penile, non-inf

CY 2011 Device HCPCS Code	CY 2011 Short Descriptor
C2626	Infusion pump, non-prog, temp
C2631	Rep dev, urinary, w/o sling
L8600	Implant breast silicone/eq
L8614	Cochlear device/system
L8680	Implt neurostim elctr each
L8685	Implt nrostm pls gen sng rec
L8686	Implt nrostm pls gen sng non
L8687	Implt nrostm pls gen dua rec
L8688	Implt nrostm pls gen dua non
L8690	Aud osseo dev, int/ext comp

**OPPS PAYMENT CHANGES FOR DRUGS, BIOLOGICALS, AND RADIOPHARMACEUTICALS**

**1. OPPS Transitional Pass-Through Payment for Additional Costs of Drugs, Biologicals, and Radiopharmaceuticals**

Proposed CY 2011 pass-through drugs and biologicals and their designated APCs are assigned status indicator “G” as indicated in Addenda A and B.

CMS’ OPPS pass-through payment estimate for drugs and biologicals for CY 2011 is \$15 million.

**2. Drugs and Biologicals with Expiring Pass-Through Status in CY 2010**

CMS is finalizing its proposal to allow the pass-through status of 18 drugs and biologicals to expire on December 31, 2010, as listed in the table below.

**Drugs and Biologicals for Which Pass-Through Status Will Expire December 31, 2010**

CY 2010 HCPCS Code	CY 2011 HCPCS Code	CY 2011 Long Descriptor	Final CY 2011 SI	Final CY 2011 APC
A9581	A9581	Injection, gadoxetate disodium, 1 ml	N	N/A
C9248	C9248	Injection, clevidipien butyrate, 1 mg	K	9248
C9356	C9356	Tendon, porous matrix of cross-linked collagen and glycosaminoglycan matrix (TenoGlide Tendon Protector Sheet), per square centimeter	N	N/A
C9358	C9358	Dermal substitute, native, non-denatured collagen, fetal bovine origin (SurgiMend Collagen Matrix), per 0.5 square centimeters	K	9358
C9359	C9359	Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold	N	N/A

CY 2010 HCPCS Code	CY 2011 HCPCS Code	CY 2011 Long Descriptor	Final CY 2011 SI	Final CY 2011 APC
		Putty, Integra OS Osteoconductive Scaffold Putty), per 0.5 cc		
J1267	J1267	Injection, doripenem, 10 mg	N	N/A
J1453	J1453	Injection, fosaprepitant, 1 mg	K	9242
J1459	J1459	Injection, immune globulin (privigen), intravenous, non-lyophilized (e.g. liquid), 500 mg	K	1214
J1571	J1571	Injection, hepatitis b immune globulin (hepagam b), intramuscular, 0.5 ml	K	946
J1573	J1573	Injection, hepatitis B immune globulin (Hepagam B), intravenous, 0.5ml	K	1138
J1953	J1953	Injection, levetiracetam, 10 mg	N	N/A
J2785	J2785	Injection, regadenoson, 0.1 mg	K	9244
J2796	J2796	Injection, romiplostim, 10 micrograms	K	9245
J9033	J9033	Injection, bendamustine hcl, 1 mg	K	9243
J9207	J9207	Injection, ixabepilone, 1 mg	K	9240
J9225	J9225	Histrelin implant (vantas), 50 mg	K	1711
J9226	J9226	Histrelin implant (supprelin la), 50 mg	K	1142
Q4114	Q4114	Dermal substitute, granulated cross-linked collagen and glycosaminoglycan matrix (Flowable Wound Matrix), 1 cc	K	1251

### **3. Drugs, Biologicals, and Radiopharmaceuticals with New or Continuing Pass-Through Status in CY 2011**

CMS is finalizing its CY 2011 pass-through payment proposals, without modification. Specifically, CMS is providing pass-through payment in CY 2011 for those 42 drugs, biologicals, and radiopharmaceuticals listed in the table below. Payment for drugs, biologicals, and radiopharmaceuticals granted pass-through status will be made at the payment rate specified in section 1842(o) of the (Social Security) Act, that is, ASP+6 percent. For drugs and biologicals that are not diagnostic radiopharmaceuticals, contrast agents, or implantable biologicals, the pass-through payment amount is equal to the difference between payment for the otherwise applicable Medicare OPD fee schedule that the Secretary determines is associated with the drug or biological, which is payment at ASP+5 percent and the payment rate specified in section 1842(o) of the Act, ASP+6 percent or the Part B drug CAP rate as applicable.

For contrast agents, diagnostic radiopharmaceuticals, and implantable biologicals, the pass-through payment is equal to the difference between the policy-packaged offset amount associated with an APC and the payment rate specified in section 1842(o) of the Act of ASP+6 percent.

**Drugs and Biologicals with Pass-Through Status in CY 2011**

<b>CY 2010 HCPCS Code</b>	<b>CY 2011 HCPCS Code</b>	<b>CY 2011 Long Descriptor</b>	<b>Final CY 2011 SI</b>	<b>Final CY 2011 APC</b>
A9582	A9582	Iodine I-123 iobenguane, diagnostic, per study dose, up to 15 millicuries	G	9247
A9583	A9583	Injection, gadofosveset trisodium, 1 ml	G	1299
C9250	C9250	Human plasma fibrin sealant, vapor-heated, solvent-detergent (Artiss), 2ml	G	9250
C9255	J2426	Injection, paliperidone palmitate, extended release, 1 mg	G	9255
C9256	J7312	Injection, dexamethasone intravitreal implant, 0.1 mg	G	9256
C9258	J3095	Injection, telavancin, 10 mg	G	9258
C9259	J9307	Injection, pralatrexate, 1 mg	G	9259
C9260	J9302	Injection, ofatumumab, 10 mg	G	9260
C9261	J3357	Injection, ustekinumab, 1 mg	G	9261
C9263	J1290	Injection, ecallantide, 1 mg	G	9263
C9264	J3262	Injection, tocilizumab, 1 mg	G	9624
C9265	J9315	Injection, romidepsin, 1 mg	G	9625
C9266	J0775	Injection, collagenase clostridium histolyticum, 0.01 mg	G	1340
C9267	J7184	Injection, von Willebrand factor complex (human), Wilate, per 100 IU VWF: RCO	G	9267
C9268	J7335	Capsaicin 8% patch, per 10 square centimeters	G	9268
C9269	J0597	Injection, C-1 Esterase inhibitor (human), Berinert, 10 units	G	9269
C9270	C9270	Injection, immune globulin (Gammaplex), intravenous, non-lyophilized (e.g. liquid), 500 mg	G	9270
C9271	J3385	Injection, velaglucerase alfa, 100 units	G	9271
C9272	C9272	Injection, denosumab, 1 mg	G	9272
C9273	C9273	Sipuleucel-T, minimum of 50 million autologous CD54+ cells activated with PAPGM-CSF in 250 mL of Lactated Ringer's, including leukapheresis and all other preparatory procedures, per infusion	G	9273
	C9274	Crotalidae polyvalent immune fab (ovine), 1 vial	G	9274
	C9275	Injection, hexaminolevulinate hydrochloride, 100 mg, per study dose	G	9275
	C9276	Injection, cabazitaxel, 1 mg	G	9276
	C9277	Injection, alglucosidase alfa (Lumizyme), 1 mg	G	9277
	C9278	Injection, incobotulinumtoxin A, 1 unit	G	9278
	C9279	Injection, ibuprofen, 100 mg	G	9279
C9360	C9360	Dermal substitute, native, non-denatured collagen, neonatal bovine origin (SurgiMend Collagen Matrix), per 0.5 square centimeters	G	9360

CY 2010 HCPCS Code	CY 2011 HCPCS Code	CY 2011 Long Descriptor	Final CY 2011 SI	Final CY 2011 APC
C9361	C9361	Collagen matrix nerve wrap (NeuroMend Collagen Nerve Wrap), per 0.5 centimeter length	G	9361
C9362	C9362	Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Strip), per 0.5 cc	G	9362
C9363	C9363	Skin substitute, Integra Meshed Bilayer Wound Matrix, per square centimeter	G	9363
C9364	C9364	Porcine implant, Permacol, per square centimeter	G	9364
C9367	C9367	Skin substitute, Endoform Dermal Template, per square centimeter	G	9367
J0598	J0598	Injection, C1 esterase inhibitor (human), 10 units	G	9251
J0641	J0641	Injection, levoleucovorin calcium, 0.5 mg	G	1236
J0718	J0718	Injection, certolizumab pegol, 1 mg	G	9249
J1680	J1680	Injection, human fibrinogen concentrate, 100 mg	G	1290
J2562	J2562	Injection, plerixafor, 1 mg	G	9252
J8705	J8705	Topotecan, oral, 0.25 mg	G	1238
J9155	J9155	Injection, degarelix, 1 mg	G	1296
J9328	J9328	Injection, temozolomide, 1 mg	G	9253
Q0138	Q0138	Injection, Ferumoxytol, for treatment of iron deficiency anemia, 1 mg	G	1297
Q2025	J8562	Fludarabine phosphate, oral, 10 mg	G	1339

**4. Provisions for Reducing Transitional Pass-Through Payments for Diagnostic Radiopharmaceuticals and Contrast Agents to Offset Costs Packaged into APC Groups**

CMS will continue to package payment for all non-pass-through diagnostic radiopharmaceuticals and contrast agents.

**a. Payment Offset Policy for Diagnostic Radiopharmaceuticals**

There is currently one radiopharmaceutical with pass-through status under the OPPS, HCPCS code A9582 (Iobenguane, I-123, diagnostic, per study dose, up to 10 millicuries). HCPCS code A9582 was granted pass-through status beginning April 1, 2009 and will continue on pass-through status in CY 2011.

CMS is finalizing its proposal to instruct hospitals to report the “FB” modifier on the line with the procedure code for the nuclear medicine scan in the APCs listed in the table below in which the no cost/full credit diagnostic radiopharmaceutical is used for CY 2011. CMS is also instructing hospitals to report a token charge of less than \$1.01 in cases in which the diagnostic radiopharmaceutical is furnished without cost or with full credit. CMS did not propose to finalize a policy to require hospitals to add an “FC” modifier to the procedure code for the nuclear medicine scan to account for diagnostic radiopharmaceuticals that are received at reduced cost.

**APCs to Which Nuclear Medicine Procedures Are Assigned for CY 2011**

APC	CY 2011 APC Title
307	Myocardial Positron Emission Tomography (PET) imaging.
308	Non-Myocardial Positron Emission Tomography (PET) imaging.
377	Level II Cardiac Imaging.
378	Level II Pulmonary Imaging.
389	Level I Non-imaging Nuclear Medicine.
390	Level I Endocrine Imaging.
391	Level II Endocrine Imaging.
392	Level II Non-imaging Nuclear Medicine.
393	Hematologic Processing & Studies.
394	Hepatobiliary Imaging.
395	GI Tract Imaging.
396	Bone Imaging.
397	Vascular Imaging.
398	Level I Cardiac Imaging.
400	Hematopoietic Imaging.
401	Level I Pulmonary Imaging.
402	Level II Nervous System Imaging.
403	Level I Nervous System Imaging.
404	Renal and Genitourinary Studies.
406	Level I Tumor/Infection Imaging.
408	Level II Tumor/Infection Imaging.
414	Level II Tumor/Infection Imaging.

**b. Payment Offset Policy for Contrast Agents**

There are currently two contrast agents with pass-through status under the OPPS: HCPCS code A9583 (Injection, gadoxetate disodium, per ml) and HCPCS code C9275 (Injection, hexaminolevulinate hydrochloride, 100 mg, per study dose). HCPCS code A9583 was granted pass-through status beginning January 1, 2010, and will continue with pass-through status in CY 2011, and HCPCS code C9275 was granted pass-through status beginning January 1, 2011, and will continue with pass-through status in CY 2011.

CMS will continue to recognize that when a contrast agent with pass-through status is billed with any procedural APC listed in the table below, a specific offset based on the procedural APC will be applied to payment for the contrast agent to ensure that duplicate payment is not made for the contrast agent.

**APCs to Which a Contrast Agent Offset May be Applicable for CY 2011**

<b>CY 2011 APC</b>	<b>CY 2011 APC Title</b>
80	Diagnostic Cardiac Catheterization.
82	Coronary or Non-Coronary Atherectomy.
83	Coronary or Non-Coronary Angioplasty and Percutaneous Valvuloplasty.
93	Vascular Reconstruction/Fistula Repair without Device.
104	Transcatheter Placement of Intracoronary Stents.
128	Echocardiogram with Contrast.
152	Level I Percutaneous Abdominal and Biliary Procedures.
229	Transcatheter Placement of Intravascular Shunts.
278	Diagnostic Urography.
279	Level II Angiography and Venography.
280	Level III Angiography and Venography.
283	Computed Tomography with Contrast.
284	Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contrast
333	Computed Tomography without Contrast followed by Contrast.
337	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast followed by Contrast.
375	Ancillary Outpatient Services When Patient Expires.
383	Cardiac Computed Tomographic Imaging.
388	Discography.
418	Insertion of Left Ventricular Pacing Elect.
442	Dosimetric Drug Administration.
653	Vascular Reconstruction/Fistula Repair with Device.
656	Transcatheter Placement of Intracoronary Drug-Eluting Stents.
662	CT Angiography.
668	Level I Angiography and Venography.
8006	CT and CTA with Contrast Composite.
8008	MRI and MRA with Contrast Composite.

**5. OPSS Payment for Drugs, Biologicals, and Radiopharmaceuticals without Pass-Through Status**

Under the CY 2010 OPSS, CMS currently pays for drugs, biologicals, and radiopharmaceuticals that do not have pass-through status in one of two ways: packaged payment into the payment for the associated service; or separate payment (individual APCs).

The final CY 2011 drug packaging threshold is increased from \$65 to \$70.

#### ***6. Packaging Determination for HCPCS Codes That Describe the Same Drug or Biological But Different Dosages***

CMS is finalizing its CY 2011 proposal, without modification, to make a single packaging determination for a drug, rather than an individual HCPCS code, when a drug has multiple HCPCS codes describing different dosages.

The rule's Table 31 contains the extensive list of these HCPCS codes.

#### ***7. Packaging of Payment for Diagnostic Radiopharmaceuticals, Contrast Agents, and Implantable Biologicals ("Policy-Packaged" Drugs and Devices)***

CMS is finalizing its CY 2011 proposals, without modification, to continue to package payment for all non-pass-through diagnostic radiopharmaceuticals, contrast agents, and implantable biologicals that are surgically inserted or implanted into the body through a surgical incision or a natural orifice, regardless of their per day costs.

#### ***8. Payment for Drugs and Biologicals without Pass-Through Status that Are Not Packaged***

##### **a. Payment for Specified Covered Outpatient Drugs (SCODs) and Other Separately Payable and Packaged Drugs and Biologicals**

CMS is finalizing its proposal to continue its CY 2010 pharmacy overhead redistribution methodology. For CY 2011, CMS is redistributing \$150 million in overhead costs from coded packaged drugs and \$50 million in overhead costs from uncoded packaged drugs to result in \$200 million in costs redistributed from packaged coded and uncoded drugs to separately payable drugs for CY 2011.

Adoption of this redistribution methodology results in payment for separately paid drugs and biologicals at ASP+5 percent for CY 2011.

##### **b. Payment Policy for Therapeutic Radiopharmaceuticals**

CMS is finalizing, without modification, to continue to pay all non-pass-through, separately payable therapeutic radiopharmaceuticals under the ASP+X payment level. For CY 2011, non-pass-through separately payable therapeutic radiopharmaceuticals will be paid at ASP+5 percent

#### ***9. Payment for Blood Clotting Factors***

CMS will announce the actual figure for the percent change in the applicable CPI and the updated furnishing fee calculation for blood clotting factors based on that figure through the applicable program instructions and postings on the CMS Web site.

#### **Estimate of OPPS Transitional Pass-Through Spending for Drugs, Biologicals, Radiopharmaceuticals, and Devices**

CMS estimates that total pass-through spending for the device categories and the drugs and biologicals that are continuing to receive pass-through payment in CY 2011 and those device categories, drugs, and non-implantable biologicals that first become eligible for pass-through payment during CY 2011 will be approximately \$57.7 million (approximately \$42.3 million for device categories and approximately \$15.5 million for drugs and biologicals), which represents 0.15 percent of total OPPS projected total payments for CY 2011. CMS estimates that pass-through spending in CY 2011 would not amount to 2.0 percent of total projected OPPS CY 2011 program spending.

#### **OPPS PAYMENT FOR BRACHYTHERAPY SOURCES**

The separately payable brachytherapy source HCPCS codes, long descriptors, APCs, status indicators, and approximate APC median costs for CY 2011 are presented in the table below.

**Separately Payable Brachytherapy Sources for CY 2011**

CY 2010 HCPCS Code	CY 2010 Long Descriptor	CY 2011 APC	CY 2011 SI	CY2011 Approximate APC Median Cost
A9527	Iodine I-125, sodium iodide solution, therapeutic, per millicurie	2632	U	\$21
C1716	Brachytherapy source, non-stranded, Gold-198, per source	1716	U	\$188
C1717	Brachytherapy source, non-stranded, High Dose Rate Iridium-192, per source	1717	U	\$217
C1719	Brachytherapy source, non-stranded, Non-High Dose Rate Iridium-192, per source	1719	U	\$28
C2616	Brachytherapy source, non-stranded, Yttrium-90, per source	2616	U	\$16,392
C2634	Brachytherapy source, non-stranded, High Activity, Iodine-125, greater than 1.01 mCi (NIST), per source	2634	U	\$56
C2635	Brachytherapy source, non-stranded, High Activity, Palladium-103, greater than 2.2 mCi (NIST), per source	2635	U	\$28
C2636	Brachytherapy linear source, non-stranded, Palladium-103, per 1MM	2636	U	\$37
C2638	Brachytherapy source, stranded, Iodine-125, per source	2638	U	\$41
C2639	Brachytherapy source, non-stranded, Iodine-125, per source	2639	U	\$36
C2640	Brachytherapy source, stranded, Palladium-103, per source	2640	U	\$72
C2641	Brachytherapy source, non-stranded, Palladium-103, per source	2641	U	\$65
C2642	Brachytherapy source, stranded, Cesium-131, per source	2642	U	\$123
C2643	Brachytherapy source, non-stranded, Cesium-131, per source	2643	U	\$66
C2699	Brachytherapy source, stranded, not otherwise specified, per source	2698	U	*\$41
C2699	Brachytherapy source, non-stranded,	2699	U	*\$28

CY 2010 HCPCS Code	CY 2010 Long Descriptor	CY 2011 APC	CY 2011 SI	CY2011 Approximate APC Median Cost
	Cesium-131, per source			

\*Median cost is that of the lowest cost stranded or non-stranded source upon which CY 2011 payment for the NOS HCPCS code is based.

### OPPS PAYMENT FOR DRUG ADMINISTRATION SERVICES

CMS is finalizing, without modification, to continue to use the five-level APC structure for drug administration services CY 2011. The rule's Table 38 displays the final configurations of the five drug administration APCs for CY 2011.

### OPPS PAYMENT FOR HOSPITAL OUTPATIENT VISITS

#### 1. Clinic Visits: New and Established Patient Visits

CMS is finalizing, without modification, to continue to define new or established patient status for the purpose of reporting the clinic visit CPT codes, on the basis of whether or not the patient has been registered as an inpatient or outpatient of the hospital within the past 3 years. CMS also is finalizing, without modification, to continue its policy of calculating median costs for clinic visits under the OPPS using historical hospital claims data.

#### 2. Emergency Department Visits

CMS is adopting, without modification, to continue paying for Type B emergency department visits in CY 2011, consistent with their median costs through 5 levels of Type B emergency department visit APCs: APC 0626 (Level 1 Type B Emergency Visits), APC 0627 (Level 2 Type B Emergency Visits), APC 0628 (Level 3 Type B Emergency Visits), APC 0629 (Level 4 Type B Emergency Visits), and APC 0630 (Level 5 Type B Emergency Visits).

CMS is assigning HCPCS codes G0380, G0381, G0382, G0383, and G0384 (the levels 1, 2, 3, 4, and 5 Type B emergency department visit Level II HCPCS codes) to APCs 0626, 0627, 0628, 0629, and 0630, respectively, for CY 2011.

The table below displays the median costs for each level of Type B emergency department visit APCs under the final CY 2011 configuration, compared to the final median costs for each level of clinic visit APCs and each level of Type A emergency department visit APCs.

### Comparison of Median Costs for Clinic Visit APCs, Type B Emergency Department Visit HCPCS Codes, and Type A Emergency Department Visit HCPCS Codes

Visit Level	CY 2011 Clinic Visit Approximate APC Median Cost	CY 2011 Type B Emergency Department Approximate APC Median Cost	CY 2011 Type A Emergency Visit Approximate APC Median Cost
Level 1	\$52	\$41	\$51
Level 2	\$74	\$59	\$86
Level 3	\$99	\$100	\$138

Level 4	\$127	\$164	\$220
Level 5	\$167	\$270	\$326

**PAYMENT FOR PARTIAL HOSPITALIZATION PROGRAM SERVICES (PHP)**

Partial hospitalization is an intensive outpatient program of psychiatric services provided to patients as an alternative to inpatient psychiatric care for individuals who have an acute mental illness.

CMS will compute four separate PHP APC per diem payment rates, two for CMHC PHPs (for Level I and Level II services using only CMHC data) and two for hospital-based PHPs (Level I and Level II services using only hospital-based PHP data).

**PROCEDURES THAT WILL BE PAID ONLY AS INPATIENT PROCEDURES**

CMS is removing the following codes from the inpatient only procedure list:

**Procedures Removed from the Inpatient List and Their Final APC Assignments  
 for CY 2011**

CPT Code	Long Descriptor	CY 2011 APC Assignment	CY 2011 Status Indicator
21193	Reconstruction of mandibular rami; horizontal, vertical, C, or L osteotomy; without bone graft	256	T
21395	Open treatment of orbital floor blowout fracture; periorbital approach with bone graft (includes obtaining graft)	256	T
25909	Amputation, forearm, through radius and ulna; reamputation	49	T

**OPPS NONRECURRING TECHNICAL AND POLICY CHANGES AND CLARIFICATIONS**

***Policies for Supervision of Outpatient Therapeutic Services in Hospitals and CAHs***

CMS has provided an extensive, perhaps exhaustive, section on its policies regarding supervision of outpatient therapeutic services in both hospitals and CAHs.

CMS is extending its decision not to enforce the requirement for direct supervision of therapeutic services provided to CAH outpatients.

CMS is expanding the scope of its decision not to enforce the requirement for direct supervision of therapeutic services to include small rural hospitals having 100 or fewer beds.

CMS is revising the definition of direct supervision for hospital outpatient therapeutic services in §410.27(a)(1)(iv)(A) and (B) to remove the reference to “on the same campus” or “in the off-campus provider-based department of the hospital” and CMS is removing the definition of “in the hospital or CAH” provided under §410.27(g) entirely.

In summary, CMS is maintaining its general requirement for direct supervision of all outpatient therapeutic services. However, CMS is redefining the definition of direct supervision in §410.27(a)(1)(iv) to remove all references to physical boundaries and require only “immediate availability.” CMS is removing §407.27(g), which

defines “in the hospital”, because it is no longer necessary. In addition, during CY 2011 CMS will develop an independent review process for annual consideration of requests for alternative service specific supervision levels, supported by an independent technical committee, potentially by the APC Panel.

**Payment for Preventive Services**

The following table displays the HCPCS codes (paid under the OPPS or at reasonable cost) that will be recognized as “preventive services” under section 1861(ddd)(3)(A) of the Act.

**CY 2011 Deductible and Coinsurance for OPPS Preventive Services**

**Specified in Section 1861(ddd)(3)(A) of the Act\***

**(Includes the Initial Preventive Physical Examination (IPPE))**

Service	CY 2011 CPT/ HCPCS Code	Long Descriptor	USPSTF Rating <sup>1</sup>	CY 2010 Coinsurance Deductible	CY 2011 Coinsurance Deductible
Initial Preventive Physical Examination (IPPE)	G0402	Initial preventive physical examination; face to face visits, services limited to new beneficiary during the first 12 months of Medicare enrollment	*Not Rated	Coinsurance applies and deductible is waived	Waived
	G0404	Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination		Not Waived	Not Waived
Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)	G0389	Ultrasound, B-scan and/or real time with image documentation; for abdominal aortic aneurysm (AAA) ultrasound screening	B	Coinsurance applies and deductible is waived	Waived
Screening Pap Test (specimen collection)	Q0091	Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory	A	Coinsurance applies and deductible is waived	Waived
Screening Pelvic Exam	G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination	A	Coinsurance applies and deductible is waived	Waived
Bone Mass Measurement	G0130	Single energy x-ray absorptiometry (sexa) bone density study, one or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)	B	Not Waived	Waived
	77078	Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)		Not Waived	Waived
	77079	Computed tomography, bone mineral density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)		Not Waived	Waived

Service	CY 2011 CPT/ HCPCS Code	Long Descriptor	USPSTF Rating <sup>1</sup>	CY 2010 Coinsurance Deductible	CY 2011 Coinsurance Deductible
	77080	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)		Not Waived	Waived
	77081	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)		Not Waived	Waived
	77083	Radiographic absorptiometry (eg, photodensitometry, radiogrammetry), 1 or more sites		Not Waived	Waived
	76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method		Not Waived	Waived
Colorectal Cancer Screening	G0104	Colorectal cancer screening; flexible sigmoidoscopy	A	Coinsurance applies and deductible is waived	Waived
	G0105	Colorectal cancer screening; colonoscopy on individual at high risk		Coinsurance applies and deductible is waived	Waived
	G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk		Coinsurance applies and deductible is waived	Waived
	G0106	Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema	*Not Rated	Coinsurance applies and deductible is waived	Coinsurance applies and deductible is waived
	G0120	Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema.		Coinsurance applies and deductible is waived	Coinsurance applies and deductible is waived
Prostate Cancer Screening	G0102	Prostate cancer screening; digital rectal examination	D	Not Waived	Not Waived
Glaucoma Screening	G0117	Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist	I	Not Waived	Not Waived
	G0118	Glaucoma screening for high risk patient furnished under the direct supervision of an optometrist or ophthalmologist		Not Waived	Not Waived
Influenza Virus	90655	Influenza virus vaccine, split virus, preservative	B	Waived	Waived

Service	CY 2011 CPT/ HCPCS Code	Long Descriptor	USPSTF Rating <sup>1</sup>	CY 2010 Coinsurance Deductible	CY 2011 Coinsurance Deductible
Vaccine		free, when administered to children 6-35 months of age, for intramuscular use			
	90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use		Waived	Waived
	90657	Influenza virus vaccine, split virus, when administered to children 6-35 months of age, for intramuscular use		Waived	Waived
	Q2035	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (afluria)		N/A	Waived
	Q2036	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (flulaval)		N/A	Waived
	Q2037	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (fluvirin)		N/A	Waived
	Q2038	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (fluzone)		NA	Waived
	Q2039	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (not otherwise specified)		NA	Waived
	90660	Influenza virus vaccine, live, for intranasal use		Waived	Waived
	90662	Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use		Waived	Waived
	G0008	Administration of influenza virus vaccine		Waived	Waived
	G9141	Influenza a (h1n1) immunization administration (includes the physician counseling the patient/family)		Waived	Waived
	G9142	Influenza a (h1n1) vaccine, any route of administration		Waived	Waived
Pneumococcal Vaccine	90669	Pneumococcal conjugate vaccine, polyvalent, when administered to children younger than 5 years, for intramuscular use	B	Waived	Waived
	90670	Pneumococcal vacc, 13 val im		Waived	Waived
	90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2		Waived	Waived

Service	CY 2011 CPT/ HCPCS Code	Long Descriptor	USPSTF Rating <sup>1</sup>	CY 2010 Coinsurance Deductible	CY 2011 Coinsurance Deductible
		years or older, for subcutaneous or intramuscular use			
	G0009	Administration of pneumococcal vaccine		Waived	Waived
Hepatitis B Vaccine	90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use	A	Not Waived	Waived
	90743	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use		Not Waived	Waived
	90744	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use		Not Waived	Waived
	90746	Hepatitis B vaccine, adult dosage, for intramuscular use		Not Waived	Waived
	90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use		Not Waived	Waived
Smoking and Tobacco Cessation	G0436	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes	A	Not Waived	Waived
	G0437	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes		Not Waived	Waived

\*This table lists only the preventive services, as defined by the Affordable Care Act, that are paid under the OPPS or at reasonable cost, and excludes preventive services such as screening mammography and cardiovascular screening blood tests that are paid under another fee schedule such as the MPFS or the Clinical Laboratory Fee Schedule. A listing of all services defined by the Affordable Care Act as preventive services can be found in the CY 2011 MPFS proposed rule. CMS notes that any preventive service must meet the Medicare coverage guidelines for the service including being appropriate to the beneficiary to whom it is being furnished.

**<sup>1</sup> U.S. Preventive Services Task Force Recommendations:**

A -- The USPSTF strongly recommends that clinicians routinely provide [the service] to eligible patients. (The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.)

B -- The USPSTF recommends that clinicians routinely provide [the service] to eligible patients. (The USPSTF found at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms.)

C -- The USPSTF makes no recommendation for or against routine provision of [the service]. (The USPSTF found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation.)

D -- The USPSTF recommends against routinely providing [the service] to asymptomatic patients. (The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.)

I -- The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. (Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.)

***Extension of Waiver of Deductible to Services Furnished in Connection with or in Relation to a Colorectal Cancer Screening Test that Becomes Diagnostic or Therapeutic***

ACA Section 4104(c) waives the Part B deductible for colorectal cancer screening tests that become diagnostic regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as a screening test.

CMS is finalizing, without modification, that all surgical services furnished on the same date as a planned screening colonoscopy, planned flexible sigmoidoscopy, or barium enema be viewed as being furnished in connection with, as a result of, and in the same clinical encounter as the screening test for purposes of implementing section 4104(c)(2) of the ACA. CMS is creating new HCPCS modifier PT, effective January 1, 2011, that providers will append to the diagnostic procedure code that is reported instead of the screening colonoscopy or screening flexible sigmoidoscopy HCPCS code or as a result of the barium enema when the screening test becomes a diagnostic service.

***Payment for Pulmonary Rehabilitation (PR), Cardiac Rehabilitation (CR), and Intensive Cardiac Rehabilitation (ICR) Services Furnished to Hospital Outpatients***

CMS is clarifying that a CAH outpatient department is considered a covered setting for PR, CR and ICR programs, provided that the programs meet all of the regulatory requirements, including, but not limited to, direct supervision of all services by a physician.

**OPPS Payment Status and Comment Indicators**

The proposal's section XIII contains a description of the various codes used to identify payment status and comment indicators. For the most part, CMS did not make any changes to these codes.

**UPDATE OF THE REVISED AMBULATORY SURGICAL CENTER PAYMENT SYSTEM**

ACA Section 3401(k) requires that, effective for CY 2011 and subsequent years, any annual update under the ASC payment system be reduced by a productivity adjustment, which is equal to the 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity (as projected by the Secretary for the 10-year period ending with the applicable fiscal year, year, cost reporting period, or other annual period). Application of this productivity adjustment to the ASC payment system may result in the update to the ASC payment system being less than zero for a year and may result in payment rates under the ASC payment system for a year being less than such payment rates for the preceding year.

**Comment**

The use of the "productivity adjustment" will affect most provider payment updates in the years ahead. Its introduction for ASC payment purposes represents the first major application. As noted below, the magnitude of the adjustment is quite large and creates concern to all provider updates subject to this provision of law.

***Treatment of New Level II HCPCS Codes and Category III CPT Codes Implemented in April and July 2010 for which CMS Solicited Public Comments in the CY 2011 OPPS/ASC Proposed Rule***

CMS is adopting as final the ASC payment indicators for the covered ancillary services described by the new Level II HCPCS codes implemented in April and July 2010 through the respective quarterly update CR as shown in the tables below.

**New Level II HCPCS Codes for Covered Ancillary Services Implemented in April 2010**

CY 2011 HCPCS Code	CY 2010 HCPCS Code	CY 2010 Long Descriptor	Final CY 2011 Payment Indicator
J3095	C9258	Injection, telavancin, 10 mg	K2
J9307	C9259	Injection, pralatrexate, 1 mg	K2
J9302	C9260	Injection, ofatumumab, 10 mg	K2
J3357	C9261	Injection, ustekinumab, 1 mg	K2
J8562	C9262*	Fludarabine phosphate, oral, 1 mg	K2
J1290	C9263	Injection, ecallantide, 1 mg	K2

\*Level II HCPCS code C9262 was deleted June 30, 2010, and replaced with Q2025 effective July 1, 2010.

**New Level II HCPCS Codes for Covered Ancillary Services Implemented in July 2010**

CY 2011 HCPCS Code	CY 2010 HCPCS Code	CY 2010 Descriptor	CY 2011 Payment Indicator
J3262	C9264	Injection, tocilizumab, 1 mg	K2
J9315	C9265	Injection, romidepsin, 1 mg	K2
J0775	C9266	Injection, collagenase clostridium histolyticum, 0.1 mg	K2
J7184	C9267	Injection, von Willebrand factor complex (human), Wilate, per 100 IU VWF: RCO	K2
J7335	C9268	Capsaicin, patch, 10cm2	K2
C9367	C9367	Skin substitute, Endoform Dermal Template, per square centimeter	K2
J8562	Q2025	Fludarabine phosphate oral, 10mg	K2

CMS also is adopting as final the ASC payment indicators for the covered surgical procedures described by the new Category III CPT Codes and the new Level II HCPCS code implemented in the July 2010 CR as shown in the table below.

**New Category III CPT Codes and Level II HCPCS Code Implemented in July 2010 as ASC Covered Surgical Procedures**

CY 2011 CPT Code	CY 2010 Long Descriptor	Final CY 2011 Payment Indicator**
0226T	Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); diagnostic, including collection of specimen(s) by brushing or washing when performed	R2*
0227T	Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); with biopsy(ies)	R2*
0228T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; single level	G2
0229T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; each additional level (List separately in addition to code for primary procedure)	G2
0230T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; single level	G2
0231T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; each additional level (List separately in addition to code for primary procedure)	G2
0232T	Injection(s), platelet rich plasma, any tissue, including image guidance, harvesting and preparation when performed	R2*
C9800	Dermal injection procedure(s) for facial lipodystrophy syndrome (LDS) and provision of Radiesse or Sculptra dermal filler, including all items and supplies	R2*

\* If designation is temporary.

\*\*Payment indicators are based on a comparison of the rates according to the ASC standard rate setting methodology and the MPFS rates. At the time this final rule with comment period is being finalized for publication, current law authorizes a negative update to the MPFS payment rates for CY 2011. Therefore, this final rule with comment period reflects a negative update to the MPFS payment rates for CY 2011. If Congress revises the MPFS update for CY 2011, CMS will recalculate the ASC payment rates using the revised update factor in the January 2011 payment rate files issued to contractors and posted to the ASC Web site at <http://www.cms.gov/ASCPayment/>.

***Update to the Lists of ASC Covered Surgical Procedures and Covered Ancillary Services***

CMS is finalizing the addition of the following procedures to the CY 2011 ASC list of covered surgical procedures. CMS is not finalizing the proposed addition of CPT codes 37205 and 37206.

**New ASC Covered Surgical Procedures for CY 2010**

CY 2011 CPT/HCPCS Code	CY 2011 Long Descriptor	CY 2011 ASC Payment Indicator
37204	Transcatheter occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck	G2
37210	Uterine fibroid embolization (ufe, embolization of the uterine arteries to treat uterine fibroids, leiomyomata), percutaneous approach inclusive of vascular access, vessel selection, embolization, and all radiological supervision and interpretation, intraprocedural road mapping, and imaging guidance necessary to complete the procedure	G2
37221	Revascularization, iliac artery, unilateral, initial vessel; with transluminal stent placement(s)	G2
37223	Revascularization, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s) (List separately in addition to code for primary procedure)	G2
50593	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy	G2
52649	Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)	G2

***Covered Surgical Procedures Designated as Office-Based***

CMS is finalizing, with modification, to designate the procedures displayed in the table below as office-based for CY 2011.

**CY 2011 Final Designations of ASCs Covered Surgical Procedures Newly Designated As Permanently Office-Based**

CY 2011 CPT Code	CY 2010 Long Descriptor	CY 2010 ASC Payment Indicator	Proposed CY 2011 ASC Payment Indicator*	Final CY 2011 ASC Payment Indicator
20697	Application of multiplane (pins or wires in more than one plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; exchange (i.e., removal and replacement of strut, each	G2	P2	P2
27767	Closed treatment of posterior malleolus fracture; without manipulation	G2	P2	P2

\*Payment indicators are based on a comparison of the rates according to the ASC standard rate setting methodology and the MPFS rates. At the time this final rule with comment period is being finalized for publication, current law authorizes a negative update to the MPFS payment rates for CY 2011. Therefore, this final rule with comment period reflects a negative update to the MPFS payment rates for CY 2011. If Congress

revises the MPFS update for CY 2011, CMS will recalculate the ASC payment rates using the revised update factor in the January 2011 payment rate files issued to contractors and posted to the ASC Web site at <http://www.cms.gov/ASCPayment>

CMS did not receive any public comments that addressed its proposals to designate three procedures listed in the table below, as permanently office-based for CY 2011.

**CY 2010 Temporarily Designated Office-Based ASC Covered Surgical Procedures that Are Designated as Permanently Office-Based for CY 2011**

CY 2011 CPT Code	CY 2011 Long Descriptor	CY 2010 ASC Payment Indicator	Final CY 2011 ASC Payment Indicator**
46930	Destruction of internal hemorrhoid(s) by thermal energy (e.g., infrared coagulation, cautery, radiofrequency)	P3*	P3
64455	Injection(s), anesthetic agent and/or steroid plantar common digital nerve(s) (e.g., Morton's neuroma)	P3*	P3
64632	Destruction by neurolytic agent; plantar common digital nerve	P3*	P3

\* If designation is temporary.

\*\*Payment indicators are based on a comparison of the rates according to the ASC standard rate setting methodology and the MPFS rates. At the time this final rule with comment period is being finalized for publication, current law authorizes a negative update to the MPFS payment rates for CY 2011. Therefore, this final rule with comment period reflects a negative update to the MPFS payment rates for CY 2011. If Congress revises the MPFS update for CY 2011, CMS will recalculate the ASC payment rates using the revised update factor in the January 2011 payment rate files issued to contractors and posted to the ASC Web site at <http://www.cms.gov/ASCPayment/>.

CMS also is finalizing its proposal to designate seven procedures as temporarily office-based for CY 2011.

**CY 2010 Temporarily Designated Office-Based ASC Covered Surgical Procedures that are Designated as Temporarily Office-Based For CY 2011**

CY 2011 HCPCS Code	CY 2011 Long Descriptor	CY 2010 ASC Payment Indicator	Final CY 2011 ASC Payment Indicator**
0099T	Implantation of intrastromal corneal ring segments	R2*	R2*
0124T	Conjunctival incision with posterior extrascleral placement of pharmacological agent (does not include supply of medication)	R2*	R2*
0226T	Angoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); diagnostic, including collection of specimen(s) by brushing or washing when performed	R2*	R2*
0227T	Angoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); with biopsy(ies)	R2*	R2*
0232T	Injection(s), platelet rich plasma, any tissue, including image guidance, harvesting and preparation when performed	R2*	R2*
67229	Treatment of extensive or progressive retinopathy, one or more sessions; preterm infant (less than 37 weeks gestation at birth), performed from birth up to 1 year	R2*	R2*

	of age (eg, retinopathy of prematurity), photocoagulation or cryotherapy		
C9800	Dermal injection procedure(s) for facial lipodystrophy syndrome (LDS) and provision of Radiesse or Sculptra dermal filler, including all items and supplies	R2*	R2*

\* If designation is temporary.

\*\*Payment indicators are based on a comparison of the rates according to the ASC standard rate setting methodology and the MPFS rates. At the time this final rule with comment period is being finalized for publication, current law authorizes a negative update to the MPFS payment rates for CY 2011. Therefore, this final rule with comment period reflects a negative update to the MPFS payment rates for CY 2011. If Congress revises the MPFS update for CY 2011, CMS will recalculate the ASC payment rates using the revised update factor in the January 2011 payment rate files issued to contractors and posted to the ASC Web site at <http://www.cms.gov/ASCPayment/>.

CMS is finalizing, without modification, to maintain the 16 temporary office-based payment indicators for the new CY 2010 CPT codes as displayed in the rule's Table 58.

***ASC Covered Surgical Procedures Designated as Device-Intensive***

CMS is designating the ASC covered surgical procedures displayed in the rule's Table 59 as device-intensive for CY 2011. Each device-intensive procedure is assigned payment indicator "H8" or "J8," depending on whether it was subject to transitional payment prior to CY 2011. All of these procedures are included in Addendum AA to this final rule.

***ASC Treatment of Surgical Procedure for Removal from the OPPI Inpatient List for CY 2011***

CMS is removing three procedures from the OPPI inpatient list for CY 2011 as shown in the table below.

**Procedures Exclusion from the ASC List of Covered Procedures for CY 2011 that Were Removed from the CY 2011 OPPI Inpatient List**

CY 2011 HCPCS Code	CY 2011 Long Descriptor
21193	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft
21395	Open treatment of orbital floor blowout fracture; periorbital approach with bone graft (includes obtaining graft)
25909	Amputation, forearm, through radius and ulna; re-amputation

***Update to ASC Covered Surgical Procedure Payment Rates for CY 2011***

CMS has updated ASC payment rates for CY 2011 using the established rate calculation methodologies under §416.171. Under §416.171(c)(4), the transitional payment rates are no longer used for CY 2011 and subsequent calendar years.

***Adjustment to ASC Payments for No Cost/Full Credit and Partial Credit Devices***

For CY 2011, CMS will reduce the payment for the device implantation procedures listed in the rule's Table 61 by the full device offset amount for no cost/full credit cases. ASCs must append the modifier "FB" to the HCPCS procedure code when the device furnished without cost or with full credit is listed in the rule's Table 62, and the associated implantation procedure code is listed in Table 61. In addition, for CY 2011, CMS will reduce the payment for implantation procedures listed in Table 61 by one half of the device offset amount that would be applied if a device were provided at no cost or with full credit, if the credit to the ASC is 50 percent or more of the device cost. If the ASC receives a partial credit of 50 percent or more of the cost of a device

listed in Table 62, the ASC must append the modifier “FC” to the associated implantation procedure code if the procedure is listed in Table 61.

### ***Waiver of Coinsurance and Deductible for Certain Preventive Services***

Similar to the OPPIs waivers, discussed above, ASCs will also be subject to the same changes.

### ***Intraocular Lenses (IOLs)***

The CY 2011 ASC payment rates for IOL insertion procedures are provided in the rule’s Addendum AA.

### ***Calculation of the ASC Conversion Factor and ASC Payment Rates***

For this final CY 2011 calculation, CMS says it used the CY 2010 ASC conversion factor updated by the CY 2011 CPI-U, which is estimated as 1.5 percent, less the multifactor productivity (MFP) adjustment of 1.3 percent. The final CY 2011 ASC payment weight scaler is 0.9238.

The final ASC conversion factor of **\$41.939**, is the product of the CY 2010 conversion factor of \$41.873 multiplied by the wage index budget neutrality adjustment of 0.9996 and the MFP-adjusted CPI-U payment update of 0.2 percent.

Addenda AA and BB display the updated ASC payment rates for CY 2011 for covered surgical procedures and covered ancillary services, respectively.

## **REPORTING QUALITY DATA FOR ANNUAL PAYMENT RATE UPDATES**

### ***Hospital Outpatient Quality Data Reporting Program (HOP QDRP) Quality Measures for the CY 2012 Payment Determination***

For the CY 2011 payment determination, CMS required hospitals to continue to submit data on the existing 11 HOP QDRP measures. Seven of these 11 measures are chart-abstracted measures in two areas of importance that are also measured for the inpatient setting - AMI cardiac care and surgical care. The remaining four measures address imaging efficiency in HOPDs.

For the CY 2012 payment determination, CMS is retaining the 11 existing HOP QDRP measures for the CY 2011 payment determination and adding four new measures.

The complete list of 15 measures for the CY 2012 payment determination is shown below.

<b>Proposed HOP QDRP Measurement Set to be Used for the CY 2012 Payment Determination</b>
OP-1: Median Time to Fibrinolysis
OP-2: Fibrinolytic Therapy Received Within 30 Minutes
OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention
OP-4: Aspirin at Arrival
OP-5: Median Time to ECG
OP-6: Timing of Antibiotic Prophylaxis
OP-7: Prophylactic Antibiotic Selection for Surgical Patients
OP-8: MRI Lumbar Spine for Low Back Pain
OP-9: Mammography Follow-up Rates

OP-10: Abdomen CT – Use of Contrast Material
OP-11: Thorax CT – Use of Contrast Material
OP-12: The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their Qualified/Certified EHR System as Discrete Searchable Data*
OP- 13: Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery *
OP-14: Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT)*
OP-15: Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache*

\* New measure for CY 2012 payment determination

***HOP QDRP Quality Measures for the CY 2013 Payment Determination***

CMS is finalizing for the CY 2013 payment determination: (1) the 15 quality measures that the agency is adopting for the CY 2012 payment determination; (2) one new structural measure (Tracking Clinical Results Between Visits); (3) six new chart-abstracted measures on the topics of HOPD care transitions and ED efficiency; and (4) one new chart-abstracted measure that was originally proposed for adoption for the CY 2012 payment determination (Troponin Results for Emergency Department AMI Patients or Chest Pain Patients (with probable cardiac chest pain) Received Within 60 Minutes of Arrival), for a total of 23 measures for the CY 2013 payment determination.

Hospitals will be required to begin submitting data on the new structural measure via a Web-based tool on the QualityNet Web site in July 2012 for the period January 1, 2012 through June 2012. The submission of data for the new chart-abstracted measures for the CY 2013 payment determination will be due in August 2012.

The complete list of 23 measures for the CY 2013 payment determination is shown below.

<b>HOP QDRP Measurement Set to be Used for the CY 2013 Payment Determination</b>
OP-1: Median Time to Fibrinolysis
OP-2: Fibrinolytic Therapy Received Within 30 Minutes
OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention
OP-4: Aspirin at Arrival
OP-5: Median Time to ECG
OP-6: Timing of Antibiotic Prophylaxis
OP-7: Prophylactic Antibiotic Selection for Surgical Patients
OP-8: MRI Lumbar Spine for Low Back Pain
OP-9: Mammography Follow-up Rates
OP-10: Abdomen CT – Use of Contrast Material
OP-11: Thorax CT – Use of Contrast Material
OP-12: The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their Qualified/Certified EHR System as Discrete Searchable Data*

<b>HOP QDRP Measurement Set to be Used for the CY 2013 Payment Determination</b>
OP-13: Cardiac Imaging for Preoperative Risk Assessment for Non Cardiac Low Risk Surgery *
OP-14: Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT)*
OP-15: Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache*
OP-16: Troponin Results for Emergency Department acute myocardial infarction (AMI) patients or chest pain patients (with Probable Cardiac Chest Pain) Received Within 60 minutes of Arrival **
OP-17: Tracking Clinical Results between Visits**
OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients**
OP-19: Transition Record with Specified Elements Received by Discharged Patients**
OP-20: Door to Diagnostic Evaluation by a Qualified Medical Professional**
OP-21: ED- Median Time to Pain Management for Long Bone Fracture **
OP-22: ED- Patient Left Before Being Seen**
OP-23: ED- Head CT Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT Scan Interpretation Within 45 minutes of Arrival **

### ***HOP QDRP Quality Measures for the CY 2014 Payment Determination***

CMS decided to not finalize at this time the 6 chart-abstracted measures it proposed to adopt for the CY 2014 payment determination. However, CMS says it still intends to propose them for inclusion in the HOP QDRP CY 2014 measure set and intends to do so in the CY 2012 OPPI/ASC proposed rule.

CMS is finalizing the retention of the 23 measures adopted for the CY 2013 payment determination, but is not at this time adopting any of the new measures proposed for the CY 2014 payment determination.

### **Failure to Report**

Hospitals that fail to report the required quality data information are paid 2.0 percent less. The final CY 2011 OPPI reporting ratio is 0.980, calculated by dividing the reduced conversion factor of \$67.530 by the full conversion factor of \$68.876.

### **Changes Relating to Payments to Hospitals for Direct Graduate Medical Education (GME) and Indirect Medical Education (IME) Costs**

#### **Comment**

The ACA made a number of statutory changes relating to the determination of a hospital's FTE resident count for direct GME and IME payment purposes and the manner in which FTE resident limits are calculated and applied to hospitals under certain circumstances. CMS spends nearly 400 pages explaining the changes and how it interprets needed modifications to its regulations. The material below briefly touches on a few areas. Those with teaching programs need to review these changes in detail first to determine if their FTE resident caps may be reduced, and second if they may be eligible to apply for new FTE resident slots.

#### ***Counting Resident Time in Non-provider Settings (ACA Section 5504)***

Section 5504(a) allows a hospital to count all the time that a resident trains in a non-hospital site so long as the hospital incurs the costs of the residents' salaries and fringe benefits for the time. Section 5504(b) made similar changes for IME payment purposes.

For GME payments, the provision is effective for cost reporting periods beginning on or after July 1, 2010; for IME payments, the provision is effective for discharges occurring on or after July 1, 2010.

CMS claims that Section 5504(c) specifies that the amendments made by the provisions of sections 5504(a) and (b) shall not be applied in a manner that would require the reopening of settled cost reports except in limited circumstances.

Sections 5504(a) and (b) provide that when more than one hospital incurs these costs, either directly or through a third party, those hospitals "shall count a proportional share of the time, as determined by written agreement between the hospitals." CMS notes that hospitals must use some reasonable basis for establishing that proportion and has defined options.

#### **Counting Resident Time for Didactic and Scholarly Activities and Other Activities (ACA Section 5505)**

Section 5505(b) addressed IME and added a new clause (x) to section 1886(d)(5)(B) of the Act which allows certain non-patient care activities, including didactic conferences and seminars (but not including research not associated with the treatment or diagnosis of a particular patient), to be counted for IME purposes as well.

This statutory change is effective for cost reporting periods beginning on or after July 1, 2009.

Section 5505(a) clarifies that hospitals may count residents' vacation, sick leave, and other approved leave time toward the hospitals' direct GME FTE resident count, so long as the leave does not prolong the total time the resident participates in his or her approved program.

#### ***Reductions and Increases to Hospitals' FTE Resident Caps for GME Payment Purposes (ACA Section 5503)***

Section 5503 provides for reductions in the statutory FTE resident caps for direct GME under Medicare for certain hospitals, and authorizes a "redistribution" to other hospitals of the estimated number of FTE resident slots resulting from the reductions.

For most hospitals, the permanent FTE cap is based on: (1) for an urban hospital, the number of unweighted allopathic and osteopathic FTE residents in the hospital's most recent cost reporting period ending on or before December 31, 1996 (the "1996 cap"); (2) for a rural hospital, 130 percent of the 1996 cap, and (3) other statutory allowed adjustments.

CMS will, effective for portions of cost reporting periods beginning on or after July 1, 2011, permanently reduce a hospital's FTE resident cap by 65 percent of the difference between the reference resident level and the hospital's otherwise applicable resident limit for IME and direct GME respectively. For example, if a hospital's otherwise applicable resident limit for the reference period is 100, and its reference resident level is 80 FTEs, CMS will reduce the hospital's FTE resident cap by 13 FTEs  $[0.65 (100 - 80) = 13]$ .

CMS says that a rural hospital that has fewer than 250 beds in its most recent cost reporting period ending on or before March 23, 2010, will not be subject to a possible reduction to its FTE resident cap(s).

CMS is clarifying that the one workday administrative rule regarding didactic training time will no longer be permitted for IME or direct GME documentation and counting of time beginning with portions of cost reporting periods beginning on or after January 1, 2011

CMS is amending its policy to include both dental and medical school patient care clinics in the category of a "non-provider setting that is primarily engaged in furnishing patient care."

CMS says that to ensure that it is able to begin making payments for most hospitals based on the revised FTE resident caps by July 1, 2011, it proposed to set a date by which it will have determined a hospital's reference resident level and compared it to the hospital's otherwise applicable FTE resident cap(s) to estimate whether,

and by how much, the hospital's FTE cap(s) would be reduced. CMS proposed that this date be May 1, 2011, and that date would apply for all hospitals for purposes of determining an estimate of whether and by how much their FTE resident caps should be reduced. CMS has modified the date to May 16, 2011.

From the comments being addresses, there appears to be much confusion about the use of specific cost reporting periods to be used by providers to determine whether or not their FTE caps are subject to ACA mandated reductions, especially for cost reports that have not been settled. Additionally, there appears confusion about which FTEs are included or recognized.

CMS discusses at length, how to redistribute resident slots. CMS notes that hospitals seeking additional FTE positions need to supply certain information.

CMS notes that the ACA states that in no case will any hospital receive an FTE cap increase of more than 75 FTE positions as a result of the redistribution.

In order to be eligible for consideration for an increase a hospital must first demonstrate the likelihood that it will able to fill the slots within the first three cost reporting periods beginning on or after July 1, 2011, by meeting at least one of three criteria and by providing documentation that it meets the criterion in its application for an increase to its FTE resident cap.

CMS has revised the "Demonstrated Likelihood Criteria."

CMS has identified the following states Montana, Idaho, Alaska, Wyoming, South Dakota, Nevada, North Dakota, Mississippi, Indiana, Florida, Georgia, and Arizona with the lowest quartile for resident-to-population ratios. These states would have priority for being assigned new FTE amounts.

CMS anticipates that there will be a limited number of slots available for distribution from the redistribution pool, while there will be a great demand for those limited slots. CMS discusses at length its evaluation criteria in awarding FTE slots,

CMS has extended the time for hospitals to submit applications for increasing their FTE caps from December 1, 2010 to March 1, 2011.

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