



HIGHLIGHTS OF SIGNIFICANT MEDICARE CHANGES FOR HOSPITAL O/P DEPARTMENTS AND ASCs Effective January 1, 2009

On October 30, 2008, the Centers for Medicare & Medicaid Services (CMS) issued a public review copy of the final rule with comment period that updates payment policies and rates for both hospital outpatient departments (HOPDs) and ambulatory surgical centers (ASCs) for calendar year (CY) 2009. The “official” version of this document will be published November 18, 2008, which may then be accessed here at the [Federal Register site of the Government Printing Office](#).

Outpatient Prospective Payment System:

CMS projects that the final CY 2009 payment rates under the OPSS will result in a 3.9 percent increase in Medicare payments for providers paid under the OPSS.

Payment reduction for failure to report quality measures – As required by the Medicare law, CMS will reduce the CY 2009 payment update factor by two percentage points for most services for hospitals that were required to report quality measures but failed to meet the requirements.

New quality measures to be reported – CMS is finalizing its proposal to increase the number of measures that hospitals are required to report to receive the full CY 2010 market basket update from 7 measures in CY 2008 to 11 measures in CY 2009. CMS added four imaging efficiency measures that will be calculated using Medicare claims data.

Validation of quality reporting – CMS also is implementing a voluntary test validation program, beginning with January 2009 encounters.

Healthcare-associated (acquired) conditions – CMS describes plans to propose for HOPD a policy consistent with that already in place for inpatient care regarding hospital acquired conditions.

Changes to Ambulatory Payment Classifications (APCs):

Composite APCs for multiple imaging services - CMS is establishing five imaging composite APCs by for circumstances when two or more imaging procedures using the same imaging modality are provided in a single session. These APCs include Ultrasound; Computed tomography (CT) and computed tomographic angiography (CTA) without contrast; CT and CTA with contrast; Magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA) without contrast; and MRI and MRA with contrast.

New APCs for certain Type B emergency department visits –For CY 2009, CMS is adopting four new APCs to pay for visits to Type B emergency departments (those not open round the clock) .

Drugs and pharmacy overhead – In CY 2009, CMS will pay for separately payable drugs and biologicals under the OPSS at the average sales price (ASP) plus 4 percent.

Therapeutic radiopharmaceuticals and brachytherapy sources – CMS is extending payment for therapeutic radiopharmaceuticals and brachytherapy sources provided in HOPDs based on individual hospital charges adjusted to cost until December 31, 2009.

Charge compression –CMS continues to seek analyses and comments regarding potential changes to the revenue code-to-cost center crosswalk upon which OPSS cost estimation is based.

Change for Partial Hospitalization Services: CMS is adopting two separate Partial Hospitalization Program (PHP) rates: (1) a rate of \$157 one for days with three services, and (2) a rate of \$200 for days with four or more services.

Ambulatory Surgical Centers:

ASC Payment Rate Updates –The law does not allow an inflation update to the ASC payment system for CY 2009.

Changes to the ASC List of Covered Surgical Procedures – CMS is adding 27 surgical procedures done in ASCs for which Medicare will pay. CMS is also adding eight procedures to the list of office-based procedures (subject to payment at the lesser of the amount paid to physicians under the MPFS office practice expense or the standard ASC rate), and updating the lists of device-intensive procedures and covered ancillary services and their rates.

ASC CONDITIONS FOR COVERAGE (CFCS) FINALIZED IN OPSS/ASC RULE

Conditions for Coverage (CfCs) are health and safety standards that health care organizations must meet to participate in the Medicare and Medicaid programs. The new CfCs:

- Define an ASC as a distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following admission.
- Strengthen Patients' rights regarding disclosure of physician financial interests in the ASC; advance directives; the grievance process; and confidentiality of clinical records.
- Impose stronger obligations on the governing body of an ASC to oversee its quality assessment and performance improvement (QAPI) program
- Emphasize the importance of infection control practices.
- Strengthen the requirements for assessing the patient's condition at admission to verify that the surgery is appropriate and safe for the patient in an ASC setting,
- At discharge to ensure appropriate post-surgical care for the patient.
- Require ASCs to adopt a disaster preparedness plan.

More information is available on the CMS Web site for [Hospital Outpatient Prospective Payments](#) ,
[ASCs](#) and [Information About Drugs and Biologicals](#).