American Hospital Association

Regulatory Advisory

AHA's Regulatory Advisory, a service to members, is produced whenever there is a significant development that affects the job you do in your community.

Medicare Outpatient PPS: The Proposed Rule for 2006

A Message to AHA Members:

On July 25, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* a proposed rule with changes to the 2006 outpatient prospective payment system (PPS). This proposed rule includes statutory changes for 2006 resulting from the Medicare Modernization Act (MMA) as well as policy changes, such as revisions to the Ambulatory Payment Classification (APC) weights and rates; revised payments for drugs, devices and biologicals; payment policy changes for multiple imaging services; increased payment for sole community hospitals (SCHs); and changes in payment policy for outliers. Comments on the proposed rule are due to CMS by September 16. A final rule is expected in early November and will take effect January 1, 2006.

Go online at http://www.access.gpo.gov/su_docs/fedreg/a050725c.html and scroll down to the CMS listing to view the proposed rule.

While the proposed rule provides a 3.2 percent market basket update in payment rates for hospital outpatient services, average outpatient payments to hospitals will increase only by 1.9 percent due to offsetting reductions from expiring MMA provisions — in particular, the expiration of a provision that provided a payment floor for sole-source drugs. The update and other changes for outliers, the wage index, technology pass-through payments, and the SCH adjustment result in a proposed outpatient PPS conversion factor of $59.343 for 2006.

The rule also proposes a change in the outpatient PPS outlier policy that would reduce the target for total outlier payments to 1.0 percent — down from 2.0 percent in 2005 — of total outpatient spending in 2006. In order to meet the outlier target, CMS proposes to increase the fixed dollar threshold necessary for a service to qualify for an outlier payment to $1,575, up from $1,175 in 2005.

As required by the MMA, the proposed rule would discontinue transitional corridor "hold harmless" payments for rural hospitals with fewer than 100 beds and for rural SCHs. However, based upon the results of an MMA-mandated study, CMS is proposing a 6.6 percent payment increase for rural SCHs for 2006. This adjustment would apply to all services and procedures

paid under the outpatient PPS, excluding drugs and biologicals. The SCH payment adjustment would be budget-neutral and applied before calculating outliers and coinsurance.

CMS also proposes reducing payment when multiple imaging services are provided on the same day. In accordance with a recommendation from the Medicare Payment Advisory Commission (MedPAC), CMS proposes to make full payment for the highest paid imaging service and pay 50 percent of the APC payment rate for every additional procedure within the same family of procedures performed in the same session. The proposed rule outlines 11 families of imaging procedures by imaging modality and by contiguous body area. **The AHA will be carefully evaluating this policy to determine whether it is reasonable to reduce imaging payments in this way and the potential impact on hospitals.**

The MMA also requires that in 2006, CMS use hospital average acquisition cost in setting payment rates for certain separately payable outpatient drugs ("specified covered outpatient drugs"). In a major policy change, CMS proposes to pay for these drugs at a rate of average sales price (ASP) plus 6 percent. In compliance with another MMA requirement, CMS proposes to pay an additional 2 percent of ASP for these drugs to account for pharmacy overhead and handling costs. Changes in the reimbursement method from an average wholesale price basis to an ASP dollar approach would reduce payments to hospitals by roughly $270 million or approximately 1 percent of total projected outpatient PPS payments. **AHA will be examining these proposed changes, especially those related to handling fees, to ensure a reasonable approach.**

Again, in a disappointment to hospitals, the rule does not implement a new evaluation and management (E/M) coding system for hospital billing of emergency department and clinic visits. It has been more than two years since AHA provided CMS with recommendations on this topic from an expert panel co-chaired by the AHA and the American Health Information Management Association. We believe that these E/M coding recommendations will meet hospital needs, and we are, therefore, concerned about the absence of a standard system or guidelines. The AHA will continue to urge CMS to issue guidance to address this concern.

After reviewing this advisory, check off the following items from your to-do list:

- ✓ Share this advisory with your senior management team.

- ✓ Model the impact of the proposed APC changes on your 2006 Medicare revenue. A spreadsheet comparing the changes in APC payment rates and weights from 2001–2006 is available for AHA members at http://www.aha.org/aha/members_only/member/050824_apcrates01_06.html. Please note that you must first log-in to view the spreadsheet.

- ✓ Submit your comments on the proposed rule to CMS before the September 16 deadline. Feel free to use the AHA's comment letter as a guide; it will be available in early September at www.aha.org.

The outpatient PPS continues to be underfunded, paying hospitals about 87 cents for every dollar spent providing outpatient care to Medicare beneficiaries. Together, we must convince CMS and

Congress that inadequate payment rates and updates must be addressed to ensure continued access to outpatient services for Medicare beneficiaries.

Sincerely,

Rick Pollack
Executive Vice President August 25, 2005

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Background

On July 25, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* a proposed rule with changes to the 2006 Medicare outpatient prospective payment system (PPS). This proposed rule includes statutory changes for 2006 resulting from the Medicare Modernization Act (MMA) as well as policy changes, such as revisions to the Ambulatory Payment Classification (APC) weights and rates; revised payments for drugs, devices and biologics; payment policy changes for multiple imaging services; increased payment for sole community hospitals (SCHs); and changes in payment policy for outliers. Comments on the proposed rule are due to CMS by September 16. A final rule is expected in early November and will take effect January 1, 2006.

Go online at http://www.access.gpo.gov/su_docs/fedreg/a050725c.html and scroll down to the CMS listing to view the proposed rule.

PPS Update to the Conversion Factor

To set the final outpatient PPS conversion factor for 2006, CMS first increased the 2005 conversion factor of $56.983 by the hospital market basket increase of 3.2 percent, as required by law. In addition, CMS made the following adjustments to arrive at the proposed 2006 conversion factor of $59.343:

- Applied a budget neutrality factor of 1.002015212 to ensure that the proposed wage index revisions are budget-neutral, as required by law.
- Applied a budget neutrality factor of 0.996414263 to make the newly proposed adjustments for SCHs budget-neutral, as required by law.
- Increased the conversion factor to account for a reduction in the offset for pass-through payments. Projected pass-through payments have decreased to 0.05 percent of total outpatient PPS payments, down from the 0.1 percent used to set the 2005 conversion factor. The difference of 0.05 percent was "added back" to the proposed conversion factor for 2006.
- Increased the 2006 conversion factor by one percentage point to account for the reduction in the outlier pool from 2 percent to 1 percent of total outpatient PPS payments.

Recalibration of APC Weights

The law requires that CMS review and revise the relative payment weights for APCs at least annually. To recalibrate the relative APC weights for the proposed rule, CMS used hospital claims processed by January 1, 2005 for services furnished during 2004. As has been the case since the implementation of the outpatient PPS, CMS' proposed changes to the APC weights for 2006 continue to show significant volatility. For 65 APCs, the 2006 weights would decrease by 10 percent or more; for 11 of the APCs, the reduction is greater than 20 percent. In total, 235 APCs would experience reduced weights. Conversely, weights would increase for 175 APCs up 10 percent or more for 46 of them. Weights for 21 APCs would grow by 30 percent or more.

Wage Index for 2006

For the outpatient PPS proposed rule, CMS applies the fiscal year (FY) 2006 inpatient PPS wage index as published in the inpatient PPS proposed rule, and as corrected and posted on the CMS Web site. As in prior years, CMS states that it will use the FY 2006 inpatient PPS final rule wage indices to determine the wage adjustments and co-payment standardized amounts for the final 2006 outpatient PPS rule. The percentage of the APC payment to be adjusted by the wage index will continue to be 60 percent.

Outlier Payments

Outlier payments are added to the APC amount to mitigate hospital losses when treating high-cost cases. For 2006, CMS proposes to set the projected target for outlier payments at 1 percent of total outpatient PPS payments, down from the 2 percent outlier pool used in 2005. CMS again is proposing to establish separate thresholds for community mental health centers (CMHCs) and hospitals. Therefore, 0.006 percent of the 1 percent projected target would be allocated to CMHCs for partial hospitalization program services.

The proposed rule continues to include both a fixed-dollar outlier threshold and a percentage threshold, but **CMS proposes to raise the fixed dollar threshold to $1,575 – $400 more than in 2005 – to ensure that outlier spending does not exceed the reduced outlier target.** Thus, to be eligible for an outlier payment in 2006, the cost of a service must exceed 1.75 times the APC payment amount, *and* it must be at least $1,575 more than the APC payment amount. When the cost of a hospital outpatient service exceeds these applicable thresholds, Medicare will make an outlier payment that is 50 percent of the amount by which the cost of furnishing the service exceeds 1.75 times the APC payment rate.

While AHA is continuing to evaluate the impact of CMS' revised outlier methodology, we support the continued need for an outlier policy in all prospective payment systems.

Transitional Corridor "Hold Harmless" Payments

As required by the MMA, the proposed rule would discontinue transitional corridor "hold harmless" payments for rural hospitals with fewer than 100 beds and for rural SCHs. Cancer hospitals and children's hospitals would receive the "hold harmless" payments on a permanent basis.

Rural Adjustment for Sole Community Hospitals

The MMA required CMS to study whether the outpatient costs of rural hospitals exceed those of urban hospitals, and if so, to provide an appropriate adjustment under the outpatient PPS. CMS conducted a regression analysis of cost differences for rural and urban hospitals using 2004 claims data and each hospital's most recent cost report. Controlling for differences in labor cost, volume, and case mix complexity, the analysis revealed that rural SCHs have costs per unit that are 6.6 percent higher than urban hospitals. CMS found no significant differences between all other rural hospitals and urban hospitals. **Therefore, CMS is proposing to increase payments to SCHs by 6.6 percent for all services paid under the outpatient PPS, except for drugs and biologicals.** The adjustment would be budget-neutral, and would be applied before calculating outliers and coinsurance.

Transitional Pass-through Payments

In 1999, Congress created temporary additional or "transitional pass-through payments" for certain innovative medical devices, drugs and biologicals to ensure that Medicare beneficiaries had access to new technologies in patient care. For 2006, CMS is projecting that pass-through payments will be 0.05 percent of total outpatient PPS payments, or $12.5 million. Because changes to the transitional pass-through pool must be budget-neutral, CMS proposes to return 0.05 percent – the difference between the estimated 0.10 percent pass-through payments in 2005 and the 0.05 percent pass-through payment estimate for 2006 – to the conversion factor to fund all other APCs.

The CMS estimate of pass-through spending represents such a small percentage of total outpatient PPS spending because the three remaining pass-through device categories expire before the new year, and the agency estimates only a small expenditure for new pass-through device categories that become eligible in 2006. Additionally, pass-through payments for drugs and biologicals have been effectively eliminated due to CMS' implementation of drug payment changes stipulated in the MMA.

Payment for Medical Devices

Pass-Through Devices. By law, device categories are eligible for pass-through payments for two to three years. The three remaining device categories approved for new technology pass-through payments will expire January 1, 2006. The costs of these pass-through devices will be packaged into the APCs in which the devices are used. Although no device categories are currently projected to be eligible for pass-through payment in 2006, CMS proposes a small offset (0.05 percent) from the conversion factor to establish a pass-through pool, as required by law, for devices that could become eligible during 2006.

CMS also is proposing to change two policies affecting the eligibility of new devices for pass-through eligibility.

1. Under existing criteria for establishing a new category of devices for pass-through payment, the device must be surgically inserted or implanted. However, CMS has proposed to expand the criteria to include devices that are inserted or implanted through a natural orifice or a surgically created orifice (such as through an ostomy) within the scope of surgically implanted devices, as well as those that are inserted or implanted through a surgically created incision.

2. Also under other existing criteria for establishing a new device category for pass-through payment, devices cannot be described by any existing or previously existing category. Some individuals, however, have expressed concern that several of the device category descriptors have been overly broad and precluded some new technologies from qualifying for a new device category eligible for pass-through payment. In response, CMS proposes to create an additional category for devices that meet all of the criteria required to establish a new category for pass-through payment in instances where it believes that an existing or previously existing category descriptor does not appropriately describe the new type of device.

Proposed Policies for Device-dependent APCs in 2006. Since the inception of the outpatient PPS, CMS has claimed that problems with hospital billing data used to calculate APC weights has complicated setting payments for device-dependent APCs. CMS used several policies in setting the payment rates for 2003 through 2005 to address these concerns, including using only those claims that contained device "C" codes, making limited use of external data and applying a "dampening" policy to moderate payment reductions. In its analysis of 2004 claims data, which is the basis for setting the 2006 APC weights, CMS found serious data problems with device-dependent APCs similar to problems that existed in previous years. Therefore, CMS again proposes to adjust the median costs for certain device-dependent APCs.

For 2006, CMS proposes to adjust the median costs for these APCs to the higher of the 2006 unadjusted APC median cost (based on 2004 data) or 85 percent of the adjusted median cost on which payment is based for 2005. This policy would result in the use of adjusted medians for 10 device-dependent APCs. CMS expects that this will be the last year in which such across-the-board adjustments will be made to the median costs for these device-dependent APCs because the data that will be used to set APC weights for 2007 will reflect the policy for mandatory device coding for services furnished in 2005.

Payment for Drugs, Biologicals and Radiopharmaceuticals

Drugs and Biologicals Eligible for Transitional Pass-through Payments. In the rule, CMS identifies 10 drugs that will lose pass-through status prior to January 1, 2006. One of these 10 products will be packaged into its appropriate APC because its median cost per day falls below the $50 packaging threshold. The remaining nine drugs are assigned to their own unique APCs and will be paid based on average sales price (ASP) + 6 percent, as described below.

CMS proposes to continue pass-through status for 14 drugs in 2006. MMA requires that if a pass-through drug or biological is covered under a competitive acquisition program (CAP) contract, then the outpatient PPS payment rate is equal to the average price for the drug or biological under CAP, as calculated and adjusted by the Secretary of Health and Human Services. Bids from potential CAP vendors were due August 5, 2005; therefore, CMS currently does not have payment rates for the pass-through drugs that are included in CAP. **Pass-through drugs and biologicals not included in CAP are paid according to the ASP + 6 percent methodology.**

Drugs, Biologicals and Radiopharmaceuticals Without Pass-through Status. CMS currently pays for drugs, biologicals and radiopharmaceuticals that do not have pass-through status in one of two ways: packaged payment and separate payment (individual APCs).

- **Packaging Policy for Drugs, Biologicals and Radiopharmaceuticals:** For 2006, CMS will continue to pay separately for drugs, biologicals, and radiopharmaceuticals whose median cost per day exceeds $50 and package the cost of drugs, biologicals and radiopharmaceuticals whose median cost per day is less than $50 into the procedures with which they are billed.

- **Payment for Specified Covered Outpatient Drugs (SCODs):** MMA provisions require special classification and payment of certain separately paid drugs, biologicals and radiopharmaceuticals which had previously (commencing on or before December 31, 2002) received pass-through payments. The MMA requires that in 2006 payment for these specified covered outpatient drugs be equal to the average acquisition cost for the drug for that year as determined by the Secretary, subject to adjustment for overhead costs. The law also requires CMS to consider the hospital acquisition cost survey data collected by the Government Accountability Office (GAO) in 2004 and 2005. CMS compared the GAO price data with two other sources: (1) ASP data from the fourth quarter of 2004 and (2) mean costs for drugs derived from 2004 hospital claims data. This comparison revealed that GAO price data is roughly equivalent to ASP + 3 percent while the mean cost for drugs derived from hospital claims data is roughly equivalent to ASP + 8 percent.

  CMS proposes to pay ASP + 6 percent for separately payable drugs and biologicals in 2006: given the data described above, CMS believes this is the best estimate of average acquisition costs for 2006. ASP-based rates will be updated on a quarterly basis. For the few drugs where ASP data are unavailable, CMS proposes to use the mean costs from the 2004 hospital claims data to determine their payment rates.

- **Coding and Billing for Specified Covered Outpatient Drugs:** In 2004 and 2005, MMA required that Medicare pay different amounts for brand and generic forms of drugs. By contrast, in 2006, a single ASP-based payment rate that considers the prices for both forms of the drug will be calculated. Therefore, it is no longer necessary to differentiate between the brand and generic forms of a drug; CMS proposes to discontinue use of the C-codes that were created to represent the brand name drugs. In 2006, CMS proposes that hospitals use the health care common procedure coding system (HCPCS) codes for generic drugs to bill for both brand and generic drug forms as they did prior to implementation of the temporary MMA provision.

- **Payment for Radiopharmaceutical Agents:** While CMS considers radiopharmaceuticals to be SCODs, the agency lacks ASP data on which to base the payment rates for radiopharmaceuticals. **Therefore, CMS proposes to pay for radiopharmaceutical agents based on hospital charges adjusted to cost using the hospital cost-to-charge ratio (CCR).**

Payment Policy for Pharmacy Overhead Costs: The MMA required CMS to consider the results of a MedPAC report on adjusting APC rates for SCODs to take into account pharmacy overhead and related expenses, such as pharmacy services and handling costs. Based upon MedPAC's findings, CMS proposes to establish three drug-handling categories in 2006 representing drugs with potentially different handling cost requirements (excluding radiopharmaceuticals) as follows:

Drug Handling Category	C Code	Drug Handling APC	Description
Category 1	CWWWW	WWWW	• Orals (oral tablets, capsules, solutions)
Category 2	CXXXX	XXXX	• Injection/Sterile Preparation (draw up a drug for administration) • Single IV Solution/Sterile Preparation (adding a drug or drugs to a sterile IV solution) or Controlled Substances • Compounded/Reconstituted IV Preparations (requiring calculations performed correctly and then compounded correctly)
Category 3	CYYYY	YYYY	• Specialty IV or Agents requiring special handling in order to preserve their therapeutic value or Cytotoxic Agents, oral (chemotherapeutic, teratogenic, or toxic) requiring personal protective equipment (PPE) • Cytotoxic Agents (chemotherapeutic, teratogenic, or toxic) in all formulations except oral requiring PPE

For 2006, CMS proposes to add 2 percent of ASP to the payment rates for drugs and biologicals to cover pharmacy handling costs and instruct hospitals to charge the appropriate pharmacy overhead C-code for overhead costs associated with each administration of each separately payable drug and biological based on the code description which best reflects the service the hospital provides to prepare the product for administration to a patient. CMS intends to collect hospital charges for these C-codes for two years, and consider basing payment for the corresponding drug handling APCs on the charges reduced to costs in 2008, similar to the payment methodology for other procedural APCs. The 2 percent add-on would not apply to radiopharmaceuticals in 2006 because CMS proposes to pay for these products based on charges reduced to costs, and hospitals currently include the charge for pharmacy overhead costs in their charges for radiopharmaceuticals.

While the AHA agrees that it is appropriate to provide additional payments to hospitals to account for pharmacy overhead and drug handling costs, requiring hospitals to charge separately for pharmacy overhead using the C-codes described above would be extremely burdensome and unworkable. Other payers do not recognize C-codes, and this proposal would require that hospitals establish one charging procedure for Medicare and another for all other payers.

Additionally, since the policy applies only to separately payable drugs, hospitals would have to establish a separate charging procedure for drugs that are separately payable by Medicare and those that are bundled in procedural APCs. In our comment letter to CMS, the AHA will recommend that CMS take a simpler and less burdensome approach to paying hospitals for the handling costs associated with separately payable drugs and biologicals.

Payment for New Drugs, Biologicals and Radiopharmaceuticals Prior to HCPCS Code Assignment. For new drugs prior to their assignment of a HCPCS code, CMS proposes to continue the same policy that has been in effect since January 1, 2004. The MMA requires that CMS pay 95 percent of average wholesale price (AWP) for an outpatient drug, biological or radiopharmaceutical for which a HCPCS code has not been assigned. In order to receive payment fore these drugs, hospitals are required to bill by reporting the National Drug Code for the product along with a HCPCS code, C9399, unclassified drug or biological. When C9399 appears on a claim, the Outpatient Coding Editor (OCE) suspends the claim for manual pricing by the fiscal intermediary. The fiscal intermediary prices the claim at 95 percent of its AWP using the Red Book and processes the claim for payment.

Payment for Orphan Drugs. CMS proposes to pay for all 14 single-indication orphan drugs at ASP + 6 percent, plus the additional 2 percent for pharmacy handling costs.

Coding and Payment for Drug Administration. CMS proposes to continue the policy of using CPT codes to bill for drug administration services provided in the hospital outpatient department. Anticipating that the current CPT codes will no longer be effective in 2006, the proposed rule includes a crosswalk that maps the existing CPT codes to the new CPT drug administration codes scheduled to become official in 2006. CMS proposes to map the 2006 CPT codes to the existing drug administration APC similar to the process followed for 2005. As in 2005, hospitals would be expected to bill all relevant CPT codes for services provided. Payment for services within the same APC group would be collapsed by the OCE into a single per-visit APC payment. CMS notes that in order to ensure accurate payment in the future, it is important for hospitals to bill the charges for the packaged CPT codes for drug administration for 2006 (that is, the CPT codes with status indicator = N), even though there will be no separate payment for them in calendar year 2006.

Vaccines. CMS proposes to continue to pay for influenza and pneumococcal vaccines at reasonable cost in 2006. Also, CMS proposes to pay for each separately payable vaccine under its own APC instead of aggregating them into clinical APCs with other vaccines. Finally, CMS proposes to pay for all hepatitis B vaccines at reasonable cost, consistent with the payment methodology for influenza and pneumococcal vaccines.

Blood and Blood Products. CMS proposes to continue to make separate payments for blood and blood products through individual APCs for each product. The agency also proposes to establish payment rates for blood and blood products based on their 2004 claims data, utilizing an actual or simulated hospital blood-specific CCR to convert charges to costs for blood and blood products. For blood and blood products whose 2006 simulated medians would experience a decrease of more than 10 percent in comparison to their 2005 payment medians, CMS is proposing to limit the decrease in medians to 10 percent. In summary, CMS proposes to base

median costs for blood and blood products in 2006 on the greater of: (1) simulated medians calculated using 2004 claims data; or (2) 90 percent of the 2005 APC payment median for such products.

Reduction in Payment for Multiple Imaging Services

Currently, hospitals receive full APC payments for each diagnostic imaging procedure noted on a claim, regardless of how many procedures are performed using a singular modality or whether or not contiguous areas of the body are studied in the same session.

Based on a MedPAC recommendation, **CMS proposes to reduce payment in 2006 by 50 percent for the second and subsequent imaging procedures when all the procedures are performed during a single patient encounter and all are within an identified "family" of procedures that are commonly billed on the same day.** CMS identifies 11 "families" of imaging procedures by imaging *modality* and by *contiguous body area* as follows:

- Family 1—Ultrasound (Chest/Abdomen/Pelvis—Non-Obstetrical)
- Family 2— Computerized Tomography (CT) and Computerized Tomography Angiography (CTA) (Chest/Thorax/Abd/Pelvis)
- Family 3—CT and CTA (Head/Brain/Orbit/Maxillofacial/Neck)
- Family 4—Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA) (Chest/Abd/Pelvis)
- Family 5—MRI and MRA (Head/Brain/Neck)
- Family 6—MRI and MRA (Spine)
- Family 7—CT (Spine)
- Family 8—MRI and MRA (Lower Extremities)
- Family 9—CT and CTA (Lower Extremities)
- Family 10—Mr and MRI (Upper Extremities and Joints)
- Family 11—CT and CTA (Upper Extremities)

CMS argues that when multiple imaging studies occur in a single session, most of the clinical labor activities are not performed twice, and many of the supplies are not furnished twice. Using physician fee schedule "technical component" data, CMS asserts that its analysis supports a 50 percent reduction in the payment for the technical component portion of subsequent procedures. The proposed rule notes that items and services that comprise hospital facility costs under the outpatient PPS are generally very similar to those that are counted in the technical component portion of the physician fee schedule for diagnostic imaging procedures and, thereby justifies applying the result of this analysis to multiple imaging performed in the hospital outpatient department. **AHA will be evaluating the impact of this proposed policy on hospitals and will analyze whether the proposed reduction is a reasonable policy decision.**

New Technology APCs

CMS proposes to move 10 procedures currently assigned to new technology APCs into clinically appropriate APCs using 2004 claims data. Five of these procedures will migrate to APCs with a lower payment rate.

In addition, CMS has concluded that the lowest new technology APC cost band, $0-$50, spans too broad of a cost interval to accurately represent the lower costs of a growing number of procedures that qualify for the new technology payment. Therefore, the proposed rule divides this cost band into five $10 increments, resulting in the creation of an additional 10 new technology APCs (five APCs for procedures to which the multiple procedure payment reduction applies and five APCs for procedures to which it does not apply).

Evaluation and Management (E/M) Services

The AHA once again is disappointed that CMS is not proposing to implement a new evaluation and management (E/M) coding system for hospital billing of emergency department (ED) and clinic visits.

Since the implementation of the outpatient PPS, hospitals have coded clinic and ED visits using the same current procedural terminology CPT code as physicians. CMS has recognized that existing E/M codes correspond to different levels of physician effort but do not adequately describe non-physician resources. In 2003, the AHA and the American Health Information Management Association (AHIMA) convened an independent panel of experts to develop a set of coding guidelines that were submitted over a year ago to CMS.

The AHA believes that the E/M coding recommendations from the AHA-AHIMA expert panel will meet hospital needs and should be adopted by CMS. And, while we support CMS' proposal to give providers the time necessary to review and implement new provisions, we are concerned about the continued absence of a standard system or guidelines for application to hospital outpatient E/M services. The AHA will continue to urge CMS to issue guidance to address this concern.

Observation Services

Currently, Medicare provides a separate observation care payment for patients with congestive heart failure (CHF), chest pain (CP) and asthma. In order to reduce administrative burden on hospitals when attempting to differentiate between packaged and separately payable observation services, the rule proposes to adopt recommendations made by the APC Advisory Panel. In the rule, CMS proposes to:

- Discontinue HCPCS codes G0244 (observation care by facility to patient), G0263 (direct admission with CHF, CP, asthma), and G0264 (assessment other than CHF, CP, asthma)
- Create two new HCPCS codes to be used by hospitals to report all observation services:
    - GXXXX – Hospital observation services, per hour
    - GYYYY – Direct admission of patient for hospital observation care
- Shift determination of whether or not observation services are separately payable under APC 0339 from the hospital billing department to the outpatient PPS claims processing logic.

The AHA supports these proposed changes as they will result in a simpler, less burdensome and more reasonable process for providing necessary outpatient observation services.

Inpatient Only Procedures

CMS proposes to remove 25 procedures from the inpatient list and assign 23 of these procedures to clinically appropriate APCs. CMS does not assign two of the procedures to APC groups because they are anesthesia procedures for which a separate payment is not made under the outpatient PPS, so payment for these would be packaged into the procedures with which they are billed. **The AHA continues to believe this list should be eliminated as physicians, not hospitals, determine what procedures should be performed, as well as whether a patient's condition warrants an inpatient admission.**

Beneficiary Coinsurance

The proposed rule would decrease beneficiary liability for coinsurance for outpatient services. As required by law, the rule proposes to reduce the maximum coinsurance rate in 2006 for any service to 40 percent of the total payment to the hospital for that service, down from 45 percent in 2005. Overall, the average co-payments for all outpatient services would drop from 32 percent in 2005 to 30 percent of total payments in 2006. Under Medicare law, the cap on coinsurance rates is to be reduced gradually until all services have a coinsurance rate of 20 percent of the total payment.

Financial Impact on Hospitals

CMS estimates that implementing the rule's changes will result in the following per-case change in payment from 2005 to 2006 – excluding the impact of the expiration of the transitional corridor "hold harmless" payments to small rural hospitals and SCHs:

All Hospitals	**1.9%**
Urban Hospitals	1.6 %
Large Urban	0.8 %
Other Urban	2.5 %
Rural	3.5 %
Sole Community	6.5%
Other Rural	1.6%

Comments

The AHA will submit a comment letter to CMS on many of the proposed changes in the 2006 outpatient PPS rule and urges you to do the same. Comments are due to CMS by **September 16, 2005.** You can send comments via electronic mail to: http://www.cms.hhs.gov/regulations/ecomments. You can also mail written comments (one original and two copies) to the following address:

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