



## **Detailed Summary of the Final Rule for the Hospital Outpatient Prospective Payment System for 2012**

On November 1, 2011, the Centers for Medicare and Medicaid Services (CMS) released its final rule updating the Medicare Hospital Outpatient Prospective Payment System (HOPPS), Ambulatory Surgical Center Payment, Hospital Value-Based Purchasing Program, Physician Self-Referral, and Patient Notification Requirements in Provider Agreements for calendar year (CY) 2012. CMS will accept comments on the payment classifications assigned to new HCPCS codes, status indicator “NI”, identified in Addenda B, AA, and BB of this final rule with comment period ending January 3, 2012.

### **HOPPS Conversion Factor (Page 257)**

The proposed OPSS conversion factor for 2012 was \$69.420, however more recent data was available to calculate the final conversion factor. Therefore, the final hospital market basket increase for hospitals for FY 2012 was 3.0 percent, however, the Social Security Act requires that the hospital outpatient department (OPD) fee schedule increase factor be reduced by the productivity adjustment for 2012 and subsequent years. In addition, the Patient Protection and Affordable Care Act (PPACA) also requires a 0.1 percent reduction, the cancer hospital payment adjustment was 0.9978, and the adjustment for projected OPSS spending for the difference in pass-through spending was 0.07 percent. Therefore, the final OPSS conversion factor for CY 2012 is **\$70.016**. 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 conversion factor. This results in a reduced conversion factor for CY 2012 of **\$68.616** for those hospitals that fail to meet the HOP QDRP requirements.

### **Bypass List (Page 65)**

CMS received a comment recommending that CPT code 77332 (Treatment devices, design and construction; simple (simple block, simple bolus)) be added to the bypass list in order to yield additional claims for rate-setting for composite APC 8001 (LDR Prostate Brachytherapy Composite). CMS responded to the recommendation by stating that the code failed to meet the empirical criteria for inclusion on the bypass list. Specifically, of the 134 available natural single major claims, 117 (87 percent) of those claims contained packaging, which exceeds the 5 percent limit for a code to be placed on the bypass list.

would create considerable risk in assigning packaging that rightfully should be associated with CPT code 77332 to other services. Therefore, we are not adding CPT code 77332 to the bypass list for CY 2012.”

### **Calculation and Use of Cost-to-Charge Ratios (CCRs) (Page 67)**

For CY 2010, the National Uniform Billing Committee added revenue codes 860 (Magnetoencephalography (MEG); general classification) and 861 (Magnetoencephalography (MEG)). For purposes of applying a cost-to-charge ratio (CCR) to charges reported under revenue codes 860 and 861, CMS uses the nonstandard Medicare cost report cost center 3280 (Electrocardiogram (EKG) and Electroencephalography (EEG)) as the primary cost center and standard cost center 5400 (Electroencephalography (EEG)) as the secondary cost center using hospital-specific data from the Hospital Cost Report Information System (HCRIS). A commenter asked for new cost centers to be developed specifically for MEG but the request was denied due to the low volume of claim activity for these procedures.

The new standard cost centers for MRI, CT scans, and cardiac catheterization were effective for cost report periods beginning on or after May 1, 2010, on the revised cost report Form CMS-2552-10.

CMS is not finalizing relative payment weights based on the new CCR for implantable devices charged to patients for CY 2012 because they believe that the transition in reporting charges and costs for implantable medical devices from the general medical supplies cost centers to a highly specialized cost center for high cost items means that the final rule relative weights would otherwise be very different from the proposed rule relative weights. CMS will delay implementation of the new CCR until CY 2013, when they expect to provide an impact analysis that enables the public to assess the full impact of the use of the new CCR that is specific to implantable devices on payments for all services.

It is interesting to see this decision on implantable devices which set precedence for new CCRs to be implemented in the future (i.e. CT, MR, MEG). One commenter urged CMS exercise a similar degree of caution as that in the approach for the new “Implantable Devices Charged to Patients” cost center CCRs before using any data based on the new CT and MRI cost centers.

### **Data Development Process and Calculation of Median Costs (Page 86)**

CMS received comments expressing concern with the volatility of the OPPS payment rates from year to year and one commenter suggested a “stability policy” where any decreases in payment compared to the prior year could not exceed 5 percent. CMS responded that they have strived to resolve some of the potential reasons for instability from year to year. Specifically, they have continued to seek ways to use more claims data so that there are fewer APCs for which there are small numbers of single bills used

to set the APC median costs. In addition, CMS has tried to eliminate APCs with very small numbers of single bills where possible. CMS also points out that implementing such a system would make payments less reflective of the true service costs. They also point out that limiting decreases to payments across all APCs in a budget neutral system could unfairly reduce the payments for other services due to the effects of the scaling that is necessary to maintain budget neutrality and would distort the relativity of payment that is based on the cost of all services.

### **Endovascular Revascularization of the Lower Extremity (Page 141)**

CMS is finalizing its proposal, with modification, to revise the APC title for APC 0083 from “Coronary or Non-Coronary Angioplasty and Percutaneous Valvuloplasty” to “Coronary Angioplasty, Valvuloplasty, and Level I Endovascular Revascularization of the Lower Extremity”; for APC 0229, from “Transcatheter Placement of Intravascular Shunt and Stents” to “Level II Endovascular Revascularization of the Lower Extremity”; and for APC 0319, from “Endovascular Revascularization of the Lower Extremity” to “Level III Endovascular Revascularization of the Lower Extremity.” CMS is also finalizing their proposal, without modification, to continue to assign status indicator “T” (Significant procedure, multiple reductions apply) to each of these APCs.

CMS has finalized its proposal, without modification, to assign CPT code 37221 to APC 0229, which has a median cost of \$8,088 for 2012. ACR supported this move in its comments on the proposed rule.

CMS notes that when hospitals report CPT code 37223 (Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed), that CMS expects them to also report one of the following device HCPCS C-codes for the implantable stent used in those procedures:

- C1874 (Stent, coated/covered, with delivery system)
- C1875 (Stent, coated/covered, without delivery system)
- C1876 (Stent, non-coated/non-covered, with delivery system)
- C1877 (Stent, non-coated/non-covered, without delivery system)
- C2617 (Stent, non-coronary, temporary, without delivery system)
- C2625 (Stent, non-coronary, temporary, with delivery system)

Since the endovascular revascularization codes are considered device dependant APCs, it is vitally important that any devices that are used be reported on the hospital claims so that the median cost of the APCs accurately reflect the cost of the procedures.

### **Brachytherapy Sources (Page 154)**

CMS is finalizing its proposal to pay for brachytherapy sources at prospective payment rates based on their source-specific median costs for CY 2012. CMS is also finalizing their proposals to continue their policies regarding payment for HCPCS codes C2698 and

C2699 for stranded and non-stranded sources and new brachytherapy sources for which they have no claims data. As stated in the proposed rule (76 FR 42197), CMS invites hospitals and other parties to submit recommendations for new HCPCS codes to describe new brachytherapy sources consisting of a radioactive isotope, including a detailed rationale to support recommended new sources.

**Low Dose Rate (LDR) Prostate Brachytherapy Composite APC (APC 8001) (Page 175)**

CMS is finalizing, without modification, their proposal to continue paying for LDR prostate brachytherapy services using the composite APC methodology implemented for previous years. The final CY 2012 median cost for composite APC 8001 is approximately \$3,340, calculated from 595 single bills.

**Multiple Imaging Composite APCs (APCs 8004, 8005, 8006, 8007, and 8008) (Page 187)**

CMS will 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. The CY 2012 payment rates for the five multiple imaging composite APCs (APC 8004, APC 8005, APC 8006, APC 8007, and APC 8008) are based on median costs calculated from the CY 2010 claims that would have qualified for composite payment under the current policy (that is, those claims with more than one procedure within the same family on a single date of service). CMS was able to identify approximately 1.1 million "single session" claims out of an estimated 2.2 million potential composite cases, or approximately half of all eligible claims, to calculate the final CY 2012 median costs for the multiple imaging composite APCs. See Table 8 in Attachment 1 for the HCPCS codes that are subject to the multiple imaging composite policy and their respective families and approximate composite APC median costs for CY 2012.

**Process for New Level II HCPCS Codes and Category I and Category III CPT Codes for Which We Are Soliciting Public Comments on this CY 2012 OP/ASC Final Rule with Comment Period (Page 359)**

The comment period for this final rule provides for comments on new codes and their APC assignments. Attached is a table showing which new codes were created for 2012 for radiology and where they were replaced in APCs. Note that the new bundled CPT codes are listed in the first "tab" of the spreadsheet, along with the ACR/SIR/SNM recommendations for APC placement presented to CMS in September. The second "tab" of the spreadsheet (found in the lower left corner of the document), lists all other new radiology CPT codes and their 2012 APC assignments. If the ACR does not agree with any of the APC placements, we will have to submit comment during this legal comment period (ending on January 3<sup>rd</sup>) in order to have a change considered for 2013.

### **Quarterly Comments on New Code Placements (Page 337)**

CPT codes are established by the American Medical Association (AMA) and the Level II HCPCS codes are established by the CMS HCPCS Workgroup. These codes are updated and changed throughout the year. CPT and HCPCS code changes that affect the OPSS are published both through the annual rulemaking cycle and through the OPSS quarterly update Change Requests (CRs). CMS is finalizing its process for updating codes through their OPSS quarterly update CRs with a 30-day comment period. This means that the ACR will have to begin to review the new codes that are posted quarterly and comment on the APC placement of them during the quarterly comment periods.

### **Instructions to Hospitals in Setting Charges for Bundled Codes (Page 364)**

On page 364, CMS instructs hospitals for the first time on how to set their charges for bundled codes. In this final rule CMS states, “However, in particular, hospitals should be especially careful to thoughtfully establish charges for new codes that use a single code to report multiple services that were previously reported by multiple codes. It is vital in these cases that hospitals carefully establish charges that fully include all of the charges for all of the predecessor services that are reported by the new code. To fail to carefully construct the charge for a new code that reports a combination of services that were previously reported separately, particularly in the first year of the new code, under-represents the cost of providing the service describing by the new code and can have significant adverse impact on future payments under the OPSS for the individual service described by the new code.” On page 385 CMS adds, “We refer readers to the Provider Reimbursement Manual (Pub. 15-2, Part 2, Chapter 40 Hospital and Hospital Health Care, Form CMS 2552-10) for CMS’ instructions for reporting costs.” This has been an issue for myocardial perfusion imaging where the pricing is about 20% lower than it should be and may be an issue for CT of the abdomen/pelvis and all the other new bundled codes in the future.

### **Upper Gastrointestinal (GI) Services (APCs 0141, 0419, and 0422) (Page 405)**

CMS is finalizing their proposal to create new APC 0419 (Level II Upper GI Procedures), to rename APC 0422 as “Level III Upper GI Procedures”, and to reassign the HCPCS codes for upper GI procedures to the three APC configuration (APCs 0141, 0419 and 0422) for CY 2012 OPSS.

### **Adrenal Imaging (Page 463)**

In response to the proposed reassignment of CPT code 78075 (Adrenal imaging, cortex and/or medulla) from APC 0408 (Level III Tumor/Infection Imaging) to APC 0414 (Level II Tumor/Infection Imaging), the ACR asked CMS to provide their rationale for

this proposal, as we did not see any clinical reason for the change. CMS responded that remain in APC 0408. As such, they will continue to assign the code to APC 0408 for 2012.

We also suggested that CMS provide rationale in all proposed rules when any CPT placement change is proposed. CMS responded that the number of APCs and volume of HCPCS codes for which median costs are calculated prohibit a detailed explanation of each in the proposed rule.

### **Positron Emission Tomography (PET) Imaging (Page 464)**

CMS received comments on the proposed decrease in the payment rate for APC 0307 (Myocardial Positron Emission Tomography (PET) Imaging) from \$1,107 in 2011 to \$921 in 2012. The commenters were concerned with the volatility of the payment rates, particularly in view of the reduction in payment rate from 2010 to 2011. One commenter asked that CMS combine APC 037 and APC 038 (Non-Myocardial Positron Emission Tomography (PET) Imaging) into one single PET imaging APC in order to provide some payment stability. CMS responded that they agree that myocardial PET and non-myocardial PET have similar clinical characteristics, and currently, appear to have somewhat similar resource requirements. Therefore, for 2012, CMS is deleting the myocardial PET APC (APC 0307) and reassigning CPT codes 78459, 78491, and 78492 to APC 0308, which will be renamed “Positron Emission Tomography (PET) Imaging”. The new 2012 final rule median cost for the reconfigured APC 0308 is approximately \$1,038. CMS will reassess this decision for 2013 based on 2011 cost data.

### **Computed Tomography of the Abdomen and Pelvis (Page 486)**

As a result of comments submitted to CMS, testimony to the APC Panel, and meetings with CMS staff, CMS proposed two new APCs for the combined CT abdomen and pelvis codes (74176, 74177, and 74178). CMS finalized this proposal and as such, CPT code 74176 (Computed tomography, abdomen and pelvis; without contrast material) is assigned to new APC 0331 (Combined Abdominal and Pelvis CT Without Contrast) with a payment rate of \$405.60 and CPT codes 74177 (Computed tomography, abdomen and pelvis; with contrast material) and 74178 (Computed tomography, abdomen and pelvis; without contrast in one or both body regions, followed by contrast material(s) and further sections in one or both body regions) are assigned to new APC 0334 (Combined Abdominal and Pelvis CT With Contrast) with a payment rate of \$581.04. The current 2011 payment rates for CPT codes 74176, 74177, and 74178 are \$194, \$300, and \$334 respectively. Table 28 in Attachment 2 shows the crosswalk of predecessor codes use in calculating the medians for the new APCs.

CMS will reassess whether continued payment of these codes under the new APCs is appropriate for CY 2013 when charge and cost data for 2011 become available. CMS notes in the final rule that “the extent to which hospitals establish charges in a manner that reflects that the new codes report both the abdominal and pelvis CT services will

greatly affect the median costs that are calculated, using our longstanding methodology, from the charge data present on claims for services in CY 2011.”

### **Multiple Imaging Composite APCs**

<b>APC</b>	<b>2011 Payment Rate</b>	<b>Final 2012 Payment Rate</b>
8004 (Ultrasound Composite)	\$190.44	\$191.66
8005 (CT and CTA without Contrast Composite)	\$420.85	\$431.91
8006 (CT and CTA with Contrast Composite)	\$628.61	\$721.75
8007 (MRI and MRA without Contrast Composite)	\$706.09	\$699.98
8008 (MRI and MRA with Contrast Composite)	\$994.87	\$1,000.65

CMS did not make any additional changes to composite APCs related to imaging.

### **Complex Interstitial Radiation Source Application (APC 0651) (Page 499)**

For CY 2012, the final median cost for APC 0651 is approximately \$835, based on 92 single bills. An amazingly small amount of claims data is being used. CMS will continue to use this median cost to establish payment for APC 0651 for CY 2012, and are finalizing their policy for CY 2012 that CPT code 77778 (interstitial radiation source application; complex), when billed alone, will be paid at the APC 0651 payment rate.

### **Radioelement Applications (APC 0312) (Page 501)**

CMS is finalizing a CY 2012 median cost for APC 0312 of approximately \$378, based on 183 single claims. CMS points out that approximately 36 percent, of the 736 total lines reported for services that are assigned to APC 0312 in the CY 2012 final rule data, were reported as the unlisted CPT code 77799. CMS cannot use the unlisted code data for rate setting because they do not know which services are being reported on. Therefore, some of the approximately 36 percent of the lines paid under APC 0312 might be used to establish the median cost for services in APC 0312 if they had been coded specifically, or in cases in which there is no existing code for the service, a new code were to be created to describe the services being furnished. There is guidance by CMS in this rule that they could possibly improve the amount of claims used in rate setting for APC 0312 (radioelement applications) if the coding was more specific for what is being billed.

### **OPPS Transitional Pass-Through Payment for Additional Costs of Drugs, Biologicals, and Radiopharmaceuticals (Page 569)**

CMS has finalized without modification their proposal to expire the pass-through status of 19 drugs and biologicals on December 31, 2011. This includes HCPCS code A9583, (Injection, gadofosveset trisodium, 1 mL) and A9582 (Iodine I-123 iobenguane,

diagnostic, per study dose, up to 15 millicuries) which will both be bundled within the nuclear medicine procedure that was performed for 2012.

### **Drugs, Biologicals, and Radiopharmaceuticals with New or Continuing Pass-Through Status in CY 2012 (Page 577)**

If a diagnostic or therapeutic radiopharmaceutical receives pass-through status during CY 2012, CMS will pay for these drugs at a rate of the average sales price (ASP)+6 percent. If ASP data are not available for a radiopharmaceutical, CMS will provide pass-through payment at wholesale acquisition cost (WAC)+6 percent, the equivalent payment provided to pass-through drugs and biologicals without ASP information. If WAC information is also not available, CMS will provide payment for the pass-through radiopharmaceutical at 95 percent of its most recent average wholesale price (AWP).

### **OPPS Payment for Drugs, Biologicals, and Radiopharmaceuticals without Pass-Through Status (Page 604)**

The packaging threshold for CY 2012 has changed from \$80 in the proposed rule to \$75 in this final rule with comment period. This change occurred because CMS used the most recent forecast of the quarterly PPI index levels in their update of the CY 2012 packaging threshold for the final rule with comment period.

### **Payment for Drugs and Biologicals without Pass-Through Status That Are Not Packaged (Page 646)**

CMS is finalizing an ASP+X percent of ASP+4 for separately payable drugs in CY 2012. Payment for new drugs (excluding contrast agents and diagnostic radiopharmaceuticals), Non-implantable biologicals, and therapeutic radiopharmaceuticals with HCPCS codes that do not crosswalk to CY 2011 HCPCS codes, but which do not have pass-through status and for which we do not have OPPS hospital claims data, will be made at ASP+4 percent for CY 2012.

### **Policies for the Supervision of Outpatient Services in Hospitals and CAHs (Page 820)**

CMS has finalized that the APC Panel will be the entity that will advise and make independent recommendations to the agency regarding the appropriate supervision level for individual hospital outpatient therapeutic services. CMS will designate representatives of critical access hospitals (CAHs) to serve on the Panel to advise CMS regarding supervision but they will not advise CMS regarding APC groups and weights.

Given the strong stakeholder interest in changes in supervision levels for hospital outpatient therapeutic services, CMS will also provide an opportunity for public comment on their decisions (which will be based upon the Panel's recommendations) prior to finalizing them. These decisions will be issued at the sub-regulatory level. CMS will post the preliminary decisions on the OPPS Web site for public review and comment. Given

that the issues will be service-specific and therefore narrow, CMS will allow for a 30-day public comment period and will finalize decisions within 60 days of the end of the comment period. The final decisions will be effective either in July or January following the most recent APC Panel meeting.

Attachment 1 Suggested Tables

**Table 8 below lists the HCPCS codes that will be subject to the multiple imaging composite policy and their respective families and approximate composite APC median costs for CY 2012.**

**TABLE 28.--COMBINATIONS OF PREDECESSOR CPT CODES USED TO SIMULATE MEDIAN COSTS FOR THE COMBINED ABDOMINAL AND PELVIS CT CODES THAT ARE NEW FOR CY 2011**