OPPS final rule: CMS changes drug payment formula, physician supervision

CMS revised requirements for physician supervision and finalized a variety of drug reimbursement changes in the 2010 OPPS final rule released October 30, 2009.

Although CMS made numerous changes to drug reimbursement, hospital procedures won’t change because of them. Hospitals will simply receive a different payment. However, the physician supervision changes will require work to implement, says Jugna Shah, MPH, president of Nimitt Consulting in Washington, DC. “The operational impact is key because you only have 60 days to comply with everything in the final rule,” says Shah.

Physician supervision

CMS finalized several changes to the physician supervision requirements. In the final rule, it further defined “in the hospital” and “immediately available.”

Separately payable drugs

CMS finalized a variation of its proposed new payment calculation for addressing hospital pharmacy overhead costs associated with separately payable drugs and biologicals.

“In the final rule, CMS discusses various issues of determining an appropriate APC payment level for both the acquisition cost and pharmacy handling/overhead cost for separately payable drugs and takes a good first step of finally changing the methodology to account for some of the historical weaknesses,” says Shah.

However, the final result leaves hospitals with the same reimbursement rate for 2010 as hospitals had in 2009 for separately payable drugs—average sales price (ASP) plus 4%.

“This is deeply frustrating because the industry has worked diligently to help Medicare to understand that that ASP plus 4% is simply insufficient to cover drug acquisition costs and pharmacy handling costs,” Shah explains.

In addition, nonphysician practitioners—physician assistants, nurse practitioners, clinical nurse specialists, certified nurse-midwives, clinical psychologists, and licensed clinical social workers—may provide direct supervision for hospital outpatient therapeutic services when their license allows them to do so beginning this year.

Shah says compliance with the physician supervision piece has two components: the historical dimension and the requirements going forward. (For more on physician supervision, see the related story on p. 3.)

“The operational impact is key because you only have 60 days to comply with everything in the final rule.”

—Jugna Shah, MPH

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However, without CMS’ efforts to reallocate some dollars from packaged drugs to separately payable drugs, hospitals would have been faced with receiving less than the ASP, which seems unreasonable, yet that’s what CMS’ data analysis showed, Shah says.

Hospital administrators generally believe they are underpaid for drugs, but CMS seems unwilling to change its position, says Kimberly Anderwood Hoy, Esq., CPC, director of Medicare and compliance at HCPro, Inc., in Marblehead, MA. “I think it’s interesting that the two sides are so far apart on such a vital reimbursement issue,” Hoy says.

In addition to CMS’ discussion of separately payable drug reimbursement, hospitals should be aware that CMS has changed the packaging threshold from $60 to $65. More drugs will now be subject to packaging.

CMS finalized a significant change in reimbursement policy for 5-HT3 antiemetics. These drugs are generally lower-cost items that would typically fall under the packaging threshold, but CMS has allowed an exception to these by permitting separate reimbursement for the past four years. For 2010, CMS eliminates the exemption that 5-HT3 antiemetics have had and will package them.

Therapeutic radiopharmaceuticals and brachytherapy sources

CMS has tried to migrate therapeutic radiopharmaceuticals and brachytherapy sources away from cost-based reimbursement to some form of APC reimbursement for the past several years but has not succeeded. This year, CMS finally made a change to the reimbursement method for each.

“Brachytherapy will be reimbursed according to APC rates set using CMS’ usual charges-reduced-to-cost methodology, while therapeutic radiopharmaceutical reimbursement will be based on manufacturer ASP data, if available—otherwise, the regular APC rate-setting process,” says Shah. Hospitals usually fare better under cost-based reimbursement than APC fixed reimbursement rates, she says. But that may not be true for therapeutic radiopharmaceuticals, for which ASP-based reimbursement may be better.

“Hospitals cannot know the financial impact for either brachytherapy or therapeutic radiopharmaceuticals just by looking at Addendum B, as such an analysis requires a review of your current cost-based reimbursement versus CMS’ finalized payment rates for 2010,” says Shah.

CMS has attempted the same change for at least three years, but in the past, Congress has stepped in and required CMS to reimburse facilities on a charges-reduced-to-cost basis for therapeutic radiopharmaceuticals and brachytherapy sources, Hoy says. Congress may or may not step in again, but either choice could affect facilities.

Diagnostic radiopharmaceuticals and contrast agents remain packaged despite opposition from commenters.

“Taken in sum total, these drug reimbursement changes are likely to have an impact on a hospital’s bottom line,” Shah says.

Cardiac, pulmonary, and intensive cardiac rehab

The final rule implements provisions of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) that extend Medicare coverage to cardiac rehabilitation (CR), pulmonary rehabilitation (PR), and intensive cardiac rehabilitation (ICR) services for Medicare beneficiaries with cardiac conditions, chronic obstructive pulmonary disease, and certain other conditions.
Effective January 1, hospitals can bill Medicare for new PR, CR, and ICR services furnished in a physician office or in a hospital outpatient department.

Because CR, ICR, and PR services now have a separate benefit under MIPPA, they are no longer subject to the incident-to rules, but they do require direct physician supervision. Nonphysician practitioners cannot provide supervision for these services.

In response to comments that nonphysician practitioners should be permitted to provide supervision for PR, CR, and ICR services, CMS stated:

“We understand the reasoning of the commenters that PR, CR, and ICR services should require direct supervision by physicians and certain nonphysician practitioners, as we proposed for other hospital outpatient therapeutic services, given that PR, CR, and ICR services are similar to other hospital outpatient therapeutic services. However, we are unable to revise the regulations to permit nonphysician practitioners to supervise PR, CR, and ICR services. We do not believe that the law provides the flexibility for us to permit anyone other than a physician to supervise hospital outpatient PR, CR, and ICR services. (74 Federal Register 60573)”

**Chronic kidney disease education**

In the 2010 OPPS final rule, CMS also addresses the new benefit for coverage of kidney disease education services furnished by certain rural providers in outpatient departments to Medicare beneficiaries with stage IV chronic kidney disease. Qualified facilities may provide these educational services in an individual or group setting.

CMS will also provide reimbursement to hospitals that are reclassified from urban to rural status.

**Stem cell transplants**

One proposal CMS chose not to finalize involves outpatient stem cell transplants. For years, CMS has recognized separate payment for allogeneic stem cell transplants in the outpatient setting and has assigned the CPT codes in question status indicator S (significant procedure, not discounted when multiple). In the proposed rule, CMS discussed changing the status indicators for these services to C, inpatient only.

Commenters pointed out that these services are clinically appropriate and can be safely provided in limited circumstances in the outpatient setting, Shah says. Medicare agreed with the commenters and will permit allogeneic transplants for outpatients but has changed the status indicator for the donor harvesting service from S to E. The donor-related charges should be reported as part of the recipient’s transplant.

“The fact that CMS listened to provider comments about allowing allogeneic transplants and donor lymphocyte infusions in the outpatient setting when medically necessary and appropriate shows the agency’s willingness to let clinical practice drive payment policy rather than the other way around,” Shah says.

**CMS finalizes changes to physician supervision requirements**

CMS adopted a new standard for supervision of therapeutic services provided in a hospital or on-campus outpatient department as part of the 2010 OPPS final rule, released October 30, 2009.

According to the final rule, the supervising physician must be “immediately available” and present on the same campus, rather than in the department. CMS defines “in the hospital” in the new regulations and discusses “immediately available” extensively.

“Your revenue cycle team, compliance officers, legal counsel, and those involved in APC-related day-to-day issues need to be involved in carefully reviewing the latest information on physician supervision and determine...”

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if you have any gap between your current setup and what CMS is indicating it requires in terms of physician supervision,” says Jugna Shah, MPH, president of Nimitt Consulting in Washington, DC.

In the hospital

For direct supervision of hospital outpatient therapeutic services furnished in a hospital, CMS defines “in the hospital” as in the main buildings that are under the ownership and control of the hospital, operated by the hospital, and for which the hospital bills services under its billing number.

For services “in the hospital” or provided in designated on-campus provider-based departments, the supervising practitioner only needs to be on the campus, not in the department. CMS did not formally define “on the campus” but had indicated in the proposed rule that it would require the practitioner to be in a space meeting the definition of “in the hospital.”

However, based on comments submitted by providers, CMS broadened this interpretation in the final rule, stating:

We agree with the commenters that allowing the supervising physician to be in nonhospital space on the campus could make it easier for a supervising physician or nonphysician practitioner to respond immediately. Therefore, we believe it would be appropriate to allow the supervising physician or nonphysician practitioner to be located anywhere on the campus of the hospital, as long as he or she was immediately available to furnish assistance and direction throughout the performance of the procedure. (74 Federal Register 60583)

That means physicians and nonphysician practitioners providing supervision may be in a private physician office, co-located hospital, or hospital-operated provider or supplier such as a skilled nursing facility, end-stage renal disease facility, home health agency, or other nonhospital space on the hospital’s campus.

“It is important to remember they must continue to be immediately available within the stricter interpretation in this rule to take advantage of this looser interpretation of campus,” says Kimberly Anderwood Hoy, Esq., CPC, director of Medicare and compliance at HCPro, Inc., in Marblehead, MA.

CMS also made clear through a regulatory change that the direct supervision requirement for off-campus provider-based departments did not change and still requires the practitioner to be present in the off-campus department, as discussed in the 2009 final rule. CMS modified the language for off-campus departments to read “present in the off-campus provider-based department.” Previously, CMS used “present and on the premises of the location,” which it interpreted to mean in the department. CMS reiterated that the provider does not need to be in the same room.

“I think allowing the supervisor to be anywhere on the campus is going to be helpful for those departments that are in the hospitals, but the off-campus departments are still stuck with the requirement to have someone right there in the department,” says Hoy.

“The trick is going to be marrying the notion of ‘anywhere on the campus,’ which sounds like a free-for-all, with the other requirements published by CMS, including all of the components of being ‘immediately available,’ ” says Shah.

Immediately available

CMS made some important distinctions in the preamble that people will need to pay attention to, says Hoy. CMS specifies that the supervising physician must be “immediately available” to step in and take over the procedure. “They have to be immediately able to drop what they are doing and take over the procedure, if necessary,” Hoy says.

For example, if the physician is in the hospital cafeteria located on the campus, he or she would be considered “immediately available.” However, if the
physician is in the middle of providing a procedure to a patient and is unable to interrupt the procedure to provide direct supervision to another patient, then he or she would not be considered immediately available by CMS, says Shah.

CMS also specified that the person must be close enough to be able to step in, not simply anywhere on the campus. “They have to be close enough that they could intervene right away, according to CMS,” says Hoy. “CMS seems to be defining distance from the department in terms of the time it would take to respond. While they haven’t specified an appropriate time frame, they have said that an hour would be inappropriate. This leaves a wide gap for interpretation from seconds away, which doesn’t seem required, to an hour away, which is too long.”

CMS also reiterated that the practitioner providing supervision does not need to be of the same specialty as the procedure or service that is being performed. However, CMS clarified that the practitioner must have, within his or her state scope of practice and hospital-granted privileges, the ability to step in and perform the service or procedure. In addition, the practitioner providing supervision must be ready to take over the procedure at any point, not merely provide assistance in an emergency.

**Nonphysician practitioners**

CMS finalized its proposal to permit physician assistants, nurse practitioners, clinical nurse specialists, certified nurse-midwives, and clinical psychologists to provide direct supervision for hospital outpatient therapeutic services when their license allows them to do so. One change from the proposed rule is the addition of licensed clinical social workers. CMS agreed with commenters that licensed clinical social workers should also be included in the list of nonphysician practitioners allowed to provide direct supervision.

However, those changes do not apply until 2010, Hoy says. “Anyone who has been using nonphysician practitioners for supervision really needs to go back and think about whether they may have some repayment obligations,” she explains.

**Audits and reviews**

These changes come, in part, as a response to commenters, including the American Hospital Association, which complained to CMS that the rules were confusing and unclear.

In the 2009 proposed rule, CMS discussed physician supervision requirements and finalized some changes for 2009, but still received considerable comments to its proposed changes for 2010.

Hospital administrators have been concerned that the OIG, RACs, MACs, and other auditors would use the fact that hospitals have raised questions on this topic as a reason to begin investigations and potentially take back large amounts of money.

The fact that CMS has finally conceded that it can see how there was confusion on physician supervision requirements prior to 2009 should come as a huge relief to hospitals that have been concerned that audits going back to 2000 could result in financial take-backs, says Shah.

Because CMS agrees that past requirements may have been confusing, it stated that it will not sanction audits or reviews of the supervision requirements for 2000–2008. However, it also said that enforcement action would be appropriate for 2009.

“I think that makes an even stronger case for concern about enforcement in 2009. Providers should take a close look at their risk for that year in light of the clarifications published in the 2009 rule,” says Hoy. “And in light of that rule, providers will not be...”

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able to claim they did not understand the requirements of supervision for 2009.”

The final rule does make clear that nonphysician practitioners will not be able to supervise cardiac, intensive cardiac, and pulmonary rehabilitation services. Based on statutory language, CMS did not have the flexibility to change the requirement that a physician must be present to provide supervision for those services.

“I think that is something people are going to have to pay close attention to as they implement new policies allowing nonphysician practitioner supervision, because we have always lumped those services together with all of the other outpatient services,” says Hoy.

This Month’s Coding Q&A

Don’t charge for free samples

We are unsure how to report/charge for free samples that vendors give us. For example, we purchase six screws and the vendor gives us an additional 10 at no cost. How should we charge for those screws? Should we average the cost/charge over all patients?

A The sensitive issue of free samples certainly will raise some eyebrows in this time of fraud, abuse, and compliance.

In October 2001, the federal government fined TAP Pharmaceutical Products, Inc., $875 million for alleged violations of the Prescription Drug Marketing Act and criminal and civil allegations of fraudulent drug pricing and marketing.

The government alleged that TAP Pharmaceutical had participated in fraudulent pricing schemes and sales and marketing misconduct. The alleged misconduct included providing free samples of Lupron—a drug used to treat prostate cancer—to urologists, knowing that the physicians would in turn bill the Medicare program for these same free samples.

The magnitude of the TAP Pharmaceutical investigation and the financial ramifications to Medicare were great and far exceeded those of any previous scheme.

The scenario you describe raises a red flag. Consider that the term “samples” suggests a one-time event rather than an inducement to “buy six, get 10 free.” Billing Medicare for services and supplies implies that the provider incurred some real cost in providing the services or supplies and used a reasonable markup formula in doing so.

This markup formula affects the hospital’s computed cost-to-charge ratio. A hospital is not consistently following and adhering to its markup formula if it uses zero as a starting point for an item or service.

You should not charge for these “free samples” because your facility did not incur any cost in acquiring them.

Review documentation to distinguish between cardioversion, defibrillation in ED

My question pertains to CPT code 92960 (cardioversion, elective, electrical conversion of arrhythmia; external). Is code 92960 billable in the ED? For example, a patient presents in the ED with heart palpitations and dizziness. After speaking with the patient, the physician decides to perform this procedure to return the patient’s heart to a stable rhythm.

Yes, you can report 92960 when provided in the ED, if the service is medically necessary and well documented in the patient’s record. Your example describes a situation in which an elective cardioversion would be considered for treating the patient.

 Coders sometimes have difficulty determining whether the service that was provided was an elective cardioversion. You should not report the code if the service was defibrillation—there is no CPT code for...
defibrillation; the work is included in the E/M visit level or critical care.

Coders will need to review the clinical documentation and look for clues that might differentiate elective cardioversion from defibrillation:

➤ The patient will have an atrial tachyarrhythmia (fibrillation or flutter, or supraventricular tachycardia) or, less often, ventricular arrhythmia (ventricular tachycardia). Elective cardioversion would not be provided as a treatment for ventricular fibrillation.

➤ The patient gave informed consent after discussion of risks and benefits provided by the ED physician.

➤ Sedation may have been given prior to the procedure.

➤ Chemical cardioversion may have been attempted prior to electrical cardioversion.

➤ Elective cardioversion would not be provided in a cardiac arrest situation.

Elective cardioversion generally is not provided when CPR was also administered.

Specific services, setting determine appropriate code for cardiac stress test

My question pertains to stress tests and the following CPT codes:

➤ 93017: Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; tracing only, without interpretation and report

➤ 93350: Echocardiography, transthoracic, real-time with image documentation (2-D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report

➤ 93351: Echocardiography, transthoracic, real-time with image documentation (2-D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision

Historically, hospitals have charged 93350 plus 93017 for the stress testing component. Why a hospital reported 93351 instead of 93350 plus 93017? Both of these codes pay the same APC rate. Can you explain how to bill 93351 properly?

First, review the descriptor for 93351 included in your question. CPT 2009 Changes, An Insider’s View states that 93351 “was established to report a stress echocardiogram combined with a complete cardiovascular stress test.”

Contributors

We would like to thank the following contributors to our sister publication, APC Answer Letter, for answering questions that appear on pp. 6–8:

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The PICC line without a port or pump is inserted through a peripheral vein and threaded into a larger vessel. It does not include any other implantable portion.

The PICC line with a subcutaneous port is inserted peripherally. It includes an implanted subcutaneous reservoir with a self-sealing membrane. It is accessed percutaneously with a noncoring needle and requires specialized skills and additional supplies to perform the flush procedure on an implanted VAD, rather than on a nontunneled central line.

Report irrigation of implanted VADs for drug delivery systems with 96523. The 2009 CPT Manual distinguishes between different types of devices in code descriptors for central VAD procedures: 36555–36598 (i.e., nontunneled, tunneled, port, or pump).

Logic suggests that these distinctions also apply to the use of 96523. A PICC line without a port or pump is not considered a partially or totally implanted device; however, the PICC line with a port or pump would be.

Report 96523 only for a PICC flush if the line has a subcutaneous port or pump. Query your MAC regarding whether to assign a low-level E/M code if this procedure is performed in the absence of any other services on a single date.

It further states that:

Previously, code 93350 was a stand-alone code. Code 93350 has been revised to support the establishment of a child (indented) code 93351. Code 93350 is used to report the performance and interpretation of a stress echocardiogram only.

Bill codes 93015–93018 if the stress test is performed in a hospital setting, along with procedure code 93350. If the stress test and echocardiogram are performed in an office, bill combined code 93351.

Presence or absence of port or pump determines proper PICC flush code

Which CPT code is appropriate for a peripherally inserted central catheter (PICC) flush that is the only service provided during an encounter? Would code 96523 be appropriate? Its descriptor in the 2009 CPT Manual (irrigation of implanted venous access device [VAD] for drug delivery systems) does not specify complete implantation.

PICCs are a form of IV access for prolonged use. The 2009 CPT Manual (p. 174) classifies them as:

➤ PICC without a subcutaneous port or pump
➤ PICC with a subcutaneous port or pump