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Update on Medicare and Medicaid payment issues

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CMS Releases 2010 Payment Rules for Services Furnished in Hospital Outpatient Departments and Ambulatory Surgical Centers

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On October 30, 2009, the Centers for Medicare and Medicaid Services (CMS) posted its final rule updating payment policies and rates for certain services provided by hospital outpatient departments (HOPDs) and ambulatory surgical centers (ASCs) during calendar year (CY) 2010. The final rule was published in the Federal Register on November 20, 2009, and can be viewed here [PDF].

Among other changes, the rule:

- Projects a $1.9 billion increase in Medicare payments to providers under the outpatient prospective payment system (OPPS) in CY 2010, as compared to CY 2009.
- Establishes new coverage for kidney disease education services rendered by rural providers, and for comprehensive pulmonary and intensive cardiac rehabilitation services.
- Continues to require hospitals subject to the Hospital Outpatient Quality Data Reporting Program (HOP QDRP) to submit quality data or face a two-percent reduction in their annual inflation update factor.
- Implements, beginning in CY 2011, a process to validate hospital-reported HOP QDRP data for chart-abstracted measures.
- Expands the scope of hospital outpatient services for which non-physician practitioners (NPPs) may provide direct supervision to include all hospital outpatient therapeutic services (but not diagnostic services) that they are authorized to perform under state scope of practice rules and hospital-granted privileges.
- Defines "direct supervision" for hospital "incident to" outpatient

In this Issue

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therapeutic services rendered in an on-campus provider-based facility to mean that the physician or NPP is present on the campus and available to assist through the duration of the procedure. In the context of an off-campus provider-based department, the definition of "direct supervision" continues to require the physician's or NPP's presence in the off-campus facility and immediate availability to assist.

- Requires that all hospital outpatient diagnostic services furnished directly or under arrangement follow the Medicare Physician Fee Schedule physician supervision requirements for individual tests.

- Establishes payment for the acquisition and pharmacy overhead costs of separately payable drugs and biologicals without pass-through status at the average sales price (ASP), plus four percent.

- Requires that implantable biologicals that are surgically implanted, but that are not receiving pass-through payment as of January 1, 2010, will be evaluated for pass-through status using the device category pass-through process. Implantable biologicals are currently evaluated for pass-through status using the drug and biological pass-through process.

- Establishes payment for separately payable therapeutic radiopharmaceuticals at ASP plus four percent, or, in the absence of ASP data, establishes payment based on mean unit cost from hospital claims data.

- Establishes that payment for brachytherapy services will be based on the median unit costs in CY 2010.

- Maintains two separate per diem rates – $150 for days with three services, and $211 for days with four or more services – for partial hospitalization programs (PHPs) provided in community mental health centers. The multiple outlier threshold remains indexed at 3.4 times the APC payment for higher intensity PHP days.

- Updates the ASC payment rate to reflect inflation for CY 2010, based on a 1.2 percent increase to the Consumer Price Index for All Urban Consumers.

- Adds 26 procedures to the list of procedures that are covered by Medicare when performed in an ASC. The rule also designates several procedures as office-based procedures, which are subject to a payment rate that is the lesser of the national office practice expense payment to the physician and the national ASC rate, and updates the list and rates for device-intensive procedures and covered ancillary.

Ober|Kaler's Comments: The supervision changes are noteworthy, reflecting a more relaxed standard for the supervision of "incident to" therapeutic services furnished in on-campus hospital departments. For those services, the supervising physician or NPP need not be physically located in the department where the services are being furnished, but instead may be on the campus as long as the physician or NPP is immediately available.