

CMS Issues 2008 Hospital Outpatient Final Rule Effective January 1, 2008

On November 27, 2007, the Centers for Medicare & Medicaid Services (CMS) published a Final Rule in the Federal Register (72 FR 66580) that sets Medicare payments for hospital outpatient services during calendar year 2008. This Final Rule implements significant policy changes affecting hospital outpatient services paid under the HOPPS system effective January 1, 2008 and it is available at <http://www.cms.hhs.gov/HospitalOutpatientPPS> or http://www.access.gpo.gov/su_docs/fedreg/a071127c.html. On December 29, 2007, President Bush signed S2499 the Medicare, Medicaid and SCHIP extension Act of 2007 into law, changes from this law are included in the summary and in the attached tables.

Important highlights for 2008 include:

- Payments for all diagnostic radiopharmaceuticals (RP) are now bundled into the procedure payment. In Addition, CMS **finalized the bundling of many add-on or “image processing services” with the costs of the major procedures (ie. CPT 78478, 78480, and 78496).**
- CMS finalized the proposal to pay separately for **drugs**, biologicals and **therapeutic RP** costing \$60 or more per day (*threshold*). Payments for other drugs, below the \$60 threshold, will continue to be bundled into payments for their associated procedures.
- S.2499 grants a six-month (January through June 30, 2008) **extension for therapeutic RPs to be paid at the 2007 “charges to cost” methodology.** Absent congressional action, CMS will implement their finalized **new payment policy for Therapeutic RP in the second half of 2008.** CMS will set a prospective payment rate for therapeutic RP (over the \$60 drug threshold) using the CMS hospital claims data derived from charges and adjusted using department-specific cost-to-charge ratios.
- **Drugs and biologicals (above the threshold) will be paid at 105 percent** of the average sales price (ASP) for 2008, rather than the current rate of 106 percent of ASP.
- CMS will implement a new Outpatient Code Edit (OCE) that will **result in the return for correction [Edit 78 Return To Provider (RTP)] any claims for a nuclear medicine procedure that does not contain a HCPCS code and charge for a diagnostic RP effective for services furnished on or after January 1, 2008.** Hospitals may need to hold the claim so that the RP can appear on the bill with the nuclear medicine procedure or the claim for that procedure will be returned for correction.
- As partially mentioned earlier, CMS is finalizing the proposal to package the payment for *seven* categories (eg. *Diagnostic RPs, Contrast Agents and Image Processing Services as noted above*) as supportive and ancillary services. These significant bundling policies have mixed results with some Ambulatory Payment Clarifications (APCs) showing significant increases while others only show a modest increase (many increases from 2007 are clearly not sufficient to cover the now bundled costs of the radiopharmaceutical). In some cases, the increases are less than the **general overall HOPPS update of 3.8%.**

The enclosed tables summarize the impact of CMS policies effective 2008 compared to 2007.

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CMS Issues 2008 Medicare Physician Fee Schedule Final Rule

Effective January 1, 2008

On November 27, 2007, the Centers for Medicare & Medicaid Services (CMS) published a Final Rule in the Federal Register (72 FR 66222) that sets Medicare payments for physicians and Independent Diagnostic Testing Facilities (IDTF) during calendar year 2008. This Final Rule implements policy changes affecting physicians and IDTFs paid under the Resource Based Relative Value Scale (RBRVS) system also called the Medicare Physician Fee Schedule (MPFS) effective January 1, 2008 and it is available at <http://www.cms.hhs.gov/PhysicianFeeSched/> or http://www.access.gpo.gov/su_docs/fedreg/a071127c.html.

On December 28, 2007, CMS issued a final rule delaying until January 1, 2009, the applicability of the anti-markup provisions in §414.50, as revised at (72 FR 66222). This Final Rule was published in the January 3, 2008 Federal Register (73 FR 404). Finally, on December 29, 2007, President Bush signed S.2499 the, Medicare, Medicaid and SCHIP extension Act of 2007 into law, changes from this law are included in the summary and in the attached tables.

Important highlights for 2008 include:

- The recently enacted extension law grants a six-month delay in the 10.1 percentage decrease in the fee schedule and requires CMS to implement a positive **0.5 percent** update in the conversion factor for physician-related services. Therefore, the **Conversion Factor (CF) for January 1, 2008 through June 30, 2008 is set at \$38.0870. The CF for July 1, 2008 through December 31, 2008 (absent additional congressional intervention) will be set at \$34.0682.**
- S.2499, extends for six-months, a 1.0 floor on work geographic practice cost index (GPCI) adjustments in the rate formula.
- CMS adopts recommendations of the American Medical Association (AMA) RUC committee for more codes deferred from the **Five Year Review (FYR)** and to increase the value of the work component of anesthesia services by 32% resulting in a **budget neutrality (BN) adjustor of (0.8806) for 2008**, to be applied only to the physician work relative value units (RVUs) for all CPT codes. This means that CMS had to implement a negative adjustment (**-11.94% to all CPT code work RVUs**) to make the overall payments in this system budget neutral.
- CMS continues its second year of a 4-year phase-in of a **new methodology** for determining **practice expense (PE)** RVUs. For 2008, CMS applied a 50-50 blend, old with new methodology, to set rates. In general, the rates will increase over time for procedures with high equipment costs. Procedures that are less equipment intensive will see reductions over the four-year phase in process.
- Drugs, contrast agents and biologicals will continue to be paid separately at 106 percent of the average sales price (ASP). S.2499, requires CMS to adjust the ASP by using volume-weighted ASPs based upon actual sales volume.
- There are **NO changes** for **radiopharmaceutical (RP) payment methodology** in the physician office or IDTF setting for 2008. However, Medicare contractor medical directors (CMDs) do have discretion in when and how they set their RP pricing. RPs are designated in the RBRVS as "carrier priced." Therefore, CMDs could choose to bundle these products, pay at invoice or at a percentage of average wholesale price (AWP). Check with your Medicare contractor for local status and allowable rates.
- Consistent with requirements of the DRA, this Final Rule again caps payment rates for imaging services under the physician fee schedule at the amount paid for the same services when performed in hospital outpatient departments. As a result of the **HOPPS Final Rule for 2008**, many add-on CPT codes, diagnostic RP and contrast agents **are bundled** reducing the number of nuclear medicine codes affected by the DRA CAP. CMS has stated "**where there is no OPSS**

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payment for a procedure or where the OPPS for a procedure is bundled, there is no OPPS amount for the comparison with the PFS payment. Therefore, it is infeasible to apply an OPPS cap.” (72 FR 66254)

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Myocardial Perfusion Imaging with Cardiolite® or Myoview® ESTIMATES						
2008 HCPCS CPT®	Description	National HOPPS Rates 2007	National HOPPS Rates 2008	National MPFS Rates Jan to June 30, 2008 Technical -Tc	National MPFS Rates Jan to June 30, 2008 Professional-26	National MPFS Rates Jan to June 30, 2008 Global
78465	MPI; tomographic (SPECT), multiple studies	\$399.62	\$754.85 Incl Dx RP, WM & EF	\$452.85 DRA does not affect rate for 2008	\$74.27	\$527.12 DRA does not affect rate for 2008
78478	MPI; with wall motion	\$92.53	Bundled	\$44.18	\$26.66	\$70.84
78480	MPI; with ejection fraction	\$92.53	Bundled	\$44.18	\$17.52	\$61.70
93015-93018	Cardiovascular stress test <i>Choose appropriate CPT based on service provided.</i>	\$155.74 CPT 93017	\$162.72 CPT 93017	\$65.51 CPT 93017 tracing only	\$23.61 & \$15.23 CPT 93016 supervise CPT 93018 interprt. rpt	\$103.98 CPT 93015 Tracing sup, interprt. & rpt
A9500 (2) units <i>Choose RP</i>	Tc-99m sestamibi, dx, per study dose (PSD), up to 40 mCi's <i>Cardiolite®</i>	Hospital Specific Cost to Charge Ratio X Hospital Charge \$83.48† PSD	Bundled	Carrier priced: 95% of Redbook AWP or invoice \$121.70 PSD	N/A	Carrier priced: 95% of Redbook AWP or invoice \$121.70 PSD
A9502 (2) units <i>Choose RP</i>	Tc-99m tetrofosmin, dx, per study dose (PSD), up to 40 mCi's <i>Myoview®</i>	Hospital Specific Cost to Charge Ratio X Hospital Charge \$70.72† PSD	Bundled	Carrier priced: 95% of Redbook AWP or invoice \$121.05 PSD	N/A	Carrier priced: 95% of Redbook AWP or invoice \$121.05 PSD
J0152 (2) units <i>Choose Pharm Agt</i>	Injection, Adenosine for diagnostic use, 30 mg <i>Patient example 58 mgs administered</i>	\$68.93† /30mg (2) \$137.86	\$67.89† /30mg (2) \$135.78	\$68.53† /30 mgs (1Q08)	N/A	\$68.53† /30 mgs (1Q08)
J1245 (4) units <i>Choose Pharm Agt</i>	Injection, Dipyridamole per 10 mg <i>Patient example 38 mgs administered</i>	Bundled	Bundled	\$0.96† /10 mgs (1Q08)	N/A	\$0.96† /10 mgs (1Q08)
Subtotal MPI Cardiolite® & Adenosine		\$1,045.24	\$ 1,053.35	\$ 987.18	\$157.29 RPs & Stress Agents not applicable for Prof	\$1,144.10
Subtotal MPI Cardiolite® & Dipyridamole		\$907.38	\$917.57	\$ 853.96		\$1,010.88
Subtotal MPI Myoview® & Adenosine		\$1,019.72	\$1,053.35	\$ 985.88		\$1,142.80
Subtotal MPI Myoview® & Dipyridamole		\$881.86	\$917.57	\$ 852.66		\$1,009.58

† HOPPS RP rates are examples only data from CMS posted 2006 mean unit cost from hospital claims reduced to costs. MPFS drug rates are from available ASP CMS posted files. This information is being provided to help Triad's customers find accurate, source information about reimbursement of certain medical imaging procedures. This information was compiled with the assistance of Merlino Healthcare Consulting and Triad makes no representations regarding the accuracy or completeness of the information contained herein. Triad also makes no representations regarding the clinical appropriateness of any particular type of scan or any individual patients' medical treatment plan.

PET Oncology Imaging ESTIMATES						
2008 HCPCS CPT®	Description	National HOPPS Rates 2007	National HOPPS Rates 2008	National MPFS Rates Jan to June 30, 2008 Technical -Tc	National MPFS Rates Jan to June 30, 2008 Professional-26	National MPFS Rates Jan to June 30, 2008 Global
78812	PET Imaging; skull base to mid thigh	\$855.43	\$1,057.33 Incl Dx RP	\$1,057.30	\$94.07	\$1,151.37
A9552	F-18 FDG, dx, per study dose (PSD), up to 45 mCi's	Hospital Specific Cost to Charge Ratio X Hospital Charge \$224.51† PSD	Bundled	Carrier priced: Paid on invoice, set allowable or at carrier discretion may be bundled; National Rate Estimate \$250.00 PSD	N/A	Carrier priced: Paid on invoice, set allowable or at carrier discretion may be bundled; National Rate Estimate \$250.00 PSD
Total		\$1,079.94	\$ 1,057.33	\$1,307.30	\$94.07 RPs not applicable for Professional Rate	\$1,401.37
PET/CT Oncology Imaging ESTIMATES						
78815	PET/CT Imaging; skull base to mid thigh	\$950.00	\$1,057.33 Incl Dx RP	\$1,057.30	\$118.07	\$ 1,175.36
A9552	F-18 FDG, dx, per study dose (PSD), up to 45 mCi's	Hospital Specific Cost to Charge Ratio X Hospital Charge \$224.51† PSD	Bundled	Carrier priced: Paid on invoice, set allowable or at carrier discretion may be bundled; National Rate Estimate \$250.00 PSD	N/A	Carrier priced: Paid on invoice, set allowable or at carrier discretion may be bundled; National Rate Estimate \$250.00 PSD
Total		\$1,174.51	\$ 1,057.33	\$1,307.30	\$118.07 RPs not applicable for Professional Rate	\$ 1,425.36

† HOPPS RP rates are examples only data from CMS posted 2006 mean unit cost from hospital claims reduced to costs. MPFS drug rates are from available ASP CMS posted files. This information is being provided to help Triad's customers find accurate, source information about reimbursement of certain medical imaging procedures. This information was compiled with the assistance of Merlino Healthcare Consulting and Triad makes no representations regarding the accuracy or completeness of the information contained herein. Triad also makes no representations regarding the clinical appropriateness of any particular type of scan or any individual patients' medical treatment plan.