Analysis of Final Rule for 2009 Revisions to the Medicare Hospital Outpatient Prospective Payment System

The final rule for calendar year (CY) 2009 revisions to the Medicare Hospital Outpatient Prospective Payment System (OPPS) was published in the *Federal Register* on November 18, 2008. This rule is effective for services rendered on or after January 1, 2009.

This analysis covers highlights of the revisions to the OPPS that are considered to be of particular interest to health information management (HIM) professionals. Not all sections are included in this analysis. The listed page numbers refer to the beginning of the relevant section of the final rule published in the *Federal Register*. The final rule can be accessed at: http://edocket.access.gpo.gov/2008/pdf/E8-26212.pdf.

III. OPPS Ambulatory Payment Classification (APC) Group Policies (73FR68601)

III.B.3. Exceptions to the 2 Times Rule (73FR68606)

CMS has exempted the following 14 APCs from the 2 times rule for CY 2009:

0060, Manipulation Therapy
0080, Diagnostic Cardiac Catheterization
0093, Vascular Reconstruction/Fistula Repair Without Device
0105, Repair/Revision/Removal of Pacemakers, AICDs, or Vascular Devices
0141, Level I Upper GI Procedures
0245, Level I Cataract
0303, Treatment Device Construction
0330, Dental Procedures
0341, Skin Tests
0367, Level I Pulmonary Test
0409, Red Blood Cell Tests
0426, Level II Strapping and Cast Application
0432, Health and Behavior Services
0604, Level I Hospital Clinic Visits

III.C.2. Movement of Procedures from New Technology APCs to Clinical APCs (73FR68607)

Three HCPCS codes have been moved from New Technology APCs to clinically appropriate APCs. Code C9725, Placement of endorectal intracavitary applicator for high intensity brachytherapy, has been reassigned to APC 0148, Level I Anal/Rectal Procedures; code C9726, Placement and removal (if performed) of applicator into breast for radiation therapy, has been reassigned to APC 0028, Level I Breast Surgery; and code C9727, Insertion of implants into the soft palate; minimum of three implants, has been reassigned to APC 0252, Level III ENT Procedures.

HCPCS code C9723, Dynamic infrared blood perfusion imaging, has been deleted, due to lack of utilization.

III.D.2a. Implant Injection for Vesicoureteral Reflux (73FR68610)

CPT code 52327, Cystourethroscopy, including ureteral catheterization, with subureteric injection of implant material, has been reassigned from APC 0162, Level III Cystourethroscopy and other Genitourinary Procedures, to APC 0163, Level IV Cystourethroscopy and other Genitourinary Procedures.

III.D.2b. Laparoscopic Ablation of Renal Mass (73FR68611)

CPT codes 50542 (Laparoscopy, surgical; ablation of renal mass lesion(s)) and 47370 (Laparoscopy, surgical, ablation of one or more liver tumor(s); radiofrequency) have been reassigned from APC 0132, Level III Laparoscopy, to new clinical APC 0174, Level IV Laparoscopy.

III.D.4a. Suprachordial Delivery of Pharmacologic Agent (73FR68614)

CPT code 0186T, Suprachordial delivery of pharmacologic agent (does not include supply of medication), has been reassigned to APC 0237, Level II Posterior Segment Eye Procedures.

III.D.5a. Closed Treatment of Fracture of Finger/Toe/Trunk (73FR68615)

APC 0043, Closed Treatment Fracture Finger/Toe/Trunk, has been deleted. The CPT codes that were assigned to this APC have been reassigned to new APCs 0129, Level I Closed Treatment Fracture Finger/Toe/Trunk, 0138, Level II Closed Treatment Fracture Finger/Toe/Trunk, and 0139, Level III Closed Treatment Fracture Finger/Toe/Trunk. A list of these CPT codes with their final 2009 APC assignment can be found in Table 17 on page 68616 of the final rule.

III.D.5b. Arthroscopic and Other Orthopedic Procedures (73FR68618)

APCs 0041, Level I Arthroscopy, and 0042, Level II Arthroscopy, have been reconfigured. APC 0041 will be comprised of 44 procedures and APC 0042 will be comprised of 28 procedures.

III.D.5c. Surgical Wrist Procedures (73FR68619)

CPT codes 25111 (Excision of ganglion, wrist (dorsal or volar); primary) and 25112 (Excision of ganglion, wrist (dorsal or volar); recurrent) have been reassigned from APC 0053, Level I Hand Musculoskeletal Procedures, to APC 0049, Level I Musculoskeletal Procedures except Hand and Foot.

Codes 25210 (Carpectomy; one bone) and 25215 (Carpectomy; all bones of proximal row) have been reassigned from APC 0054, Level II Hand Musculoskeletal Procedures, to APC 0050, Level II Musculoskeletal Procedures except Hand and Foot.

Code 25394 has been reassigned from APC 0053 to APC 0051, Level III Musculoskeletal Procedures except Hand and Foot.

Codes 25430 (Insertion of vascular pedicle into carpal bone (e.g., Hori procedure)) and 25431 (Repair of nonunion of carpal bone (excluding carpal scaphoid (navicular))(includes obtaining graft and necessary fixation), each bone) have been reassigned from APC 0054 to APC 0051.

CPT code 25820 (Arthrodesis, wrist; limited, without bone graft (e.g., intercarpal or radiocarpal)) has been reassigned from APC 0053 to APC 0051.

III.D.5e. Insertion of Posterior Spinous Process Distraction Device (73FR68620)

CPT codes 0171T, Insertion of posterior spinous process distraction device (including necessary removal of bone or ligament for insertion and imaging guidance), lumbar, single level, and 0172T, Insertion of posterior spinous process distraction device (including necessary removal of bone or ligament for insertion and imaging guidance, lumbar, each additional level, have been reassigned from APC 0050, Level II Musculoskeletal Procedures except Hand and Foot, to APC 0052, Level IV Musculoskeletal Procedures except Hand and Foot.

III.D.6b. Implantation of Interstitial Devices (73FR68621)

CPT code 55876, Placement of interstitial device(s) for radiation therapy guidance (e.g., fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple, has been reassigned from APC 0156, Level III Urinary and Anal Procedures, to APC 0310, Level III Therapeutic Radiation Treatment Preparation.

III.D.7a. Negative Pressure Wound Therapy (73FR68623)

CPT code 97606 (Negative pressure wound therapy (e.g., vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters) has been reassigned from APC 0015, Level III Debridement and Destruction, to APC 0013, Level II Debridement and Destruction.

III.D.7e. Mental Health Services (73FR68625)

Status indicator "P" has been assigned to CPT codes 90816 through 90829, indicating that these services may be billed appropriately and paid under the OPPS only when they are part of a partial hospitalization program.

IV. OPPS Payment for Devices (73FR68628)

IV.B.2. Adjustment to OPPS Payment for No Credit/Full Credit and Partial Credit Devices - APCs and Devices Subject to the Adjustment Policy (73FR68629)

APCs 0425, Level II Arthroplasty or Implantation with Prosthesis, and 0648, Level IV Breast Surgery, along with their associated devices, have been added to the list of APCs and devices to which the payment reduction policy for no cost/full credit and partial credit devices.

V. OPPS Payment Changes for Drugs, Biologicals, and Radiopharmaceuticals (73FR68632)

V.A.2. Drugs and Biologicals with Expiring Pass-Through Status in CY 2008 (73FR68633)

Payment for any biological without pass-through status that is surgically inserted or implanted (through a surgical incision or a natural orifice) is packaged into the payment for the associated surgical procedure for CY 2009. As a result, HCPCS codes C9352, Microporous collagen implantable tube (Neurogen Nerve Guide), per centimeter length, C9353, Microporous collagen implantable slit tube (NeuraWrap Nerve Protector), per centimeter length), and J7348, Dermal (substitute) tissue of nonhuman origin, with or without other bioengineered or processed elements, without metabolically active elements (Tissuemend), per square centimeter, are packaged and assigned status indicator "N." Any new biological without pass-through status that are surgically inserted or implanted (through a surgical incision or a natural orifice) have been packaged, beginning in CY 2009.

For non-pass-through biological that may sometimes be used as implantable devices, the Centers for Medicare & Medicaid Services (CMS) continue to instruct hospitals to not bill separately for the HCPCS codes for the products when used as implantable devices.

The 15 drugs and biologicals for which pass-through status has expired, effective December 31, 2008, are listed in Table 23 of the final rule (page 68636).

V.B.5. Payment for Nonpass-Through Drugs, Biologicals, and Radiopharmaceuticals with HCPCS Codes, but Without OPPS Hospital Claims Data (73FR68663)

In CY 2008, CMS began recognizing, for OPPS payment purposes, multiple HCPCS codes indicating different dosages for covered Part B drugs. CMS also implemented a policy that assigned the status indicator of the previously recognized HCPCS code to the associated newly recognized code(s). For CY 2009, this methodology is being continued, and this policy is being applied to 6 additional HCPCS drug codes. These codes can be found in Table 31 on page 68665 in the final rule.

VIII. OPPS Payment for Drug Administration Services (73FR68671)

VIII.B. Coding and Payment for Drug Administration Services (73FR68671)

CMS has implemented a five-level APC structure for drug administration services. They will continue to use the full range of CPT drug administration codes. Table 34 on page 68674 in the final rule displays the five APC groups for drug administration services.

Payment for CPT code 90768 (Intravenous infusion, for therapy, prophylaxis, or diagnosis; concurrent infusion) has been packaged for CY 2009.

IX. OPPS Payment for Hospital Outpatient Visits (73FR68676)

IX.B.1. Clinic Visits: New and Established Patient Visits (73FR68677)

The definitions of "new" and "established" patients as they apply to hospital outpatient visits have been modified. Beginning in CY 2009, the meanings of "new" and "established" patients pertain to whether or not the patient has been registered as an inpatient or outpatient of the hospital within the past 3 years. A patient how has been registered as an inpatient or outpatient of the hospital within the 3 years prior to the visit is considered to be an established patient for that visit, while a patient who has not been registered as an inpatient or outpatient of the hospital within the 3 years prior to the visit is considered to be a new patient for that visit.

IX.B.2. Emergency Department Visits (73FR68680)

Levels 1 through 4 Type B emergency department visits have been assigned to their own newly-created APCs: 0626 (Level 1 Type B Emergency Visits), 0627 (Level 2 Type B Emergency Visits), 0628 (Level 3 Type B Emergency Visits), and 0629 (Level 4 Type B Emergency Visits). To distinguish the new APCs from the APCs for levels 1, 2, 3, and 4 Type A emergency department visits, the titles of the current APCs for these visits have been modified to reflect "Type A." The level 5 Type B emergency department visits have been assigned to the same APC as the level 5 Type A emergency department visits. HCPCS code G0384, Level 5 Type B emergency visit, has been included in the criteria for determining eligibility for payment of composite APC 8003 (Level II Extended Assessment and Management Composite).

IX.B.3. Visit Reporting Guidelines (73FR68684)

CMS continues to observe a normal and stable distribution of clinic and emergency department visit levels in hospital claims. They continue to believe that, based on the use of their own internal guidelines, hospitals are generally billing in an appropriate and consistent manner that distinguishes among different levels of visits based on their required hospital resources. CMS is encouraging hospitals to continue to report visits during CY 2009 according to their own internal hospital guidelines. National guidelines for reporting hospital visits are not being implemented in CY 2009.

In response to public comments requesting clarification of services that should be included or bundled into visit codes, CMS noted that hospitals should separately report

all HCPCS codes in accordance with correct coding principles, CPT code descriptions, and any additional CMS guidance, when available.

In the absence of national guidelines, CMS will continue to regularly re-evaluate patterns of hospital outpatient visit reporting at varying levels of disaggregation below the national level to ensure that hospitals continue to bill appropriately and differentially for these services.

X. Payment for Partial Hospitalization Services (73FR68686)

X.C.3. Partial Hospitalization Coding Update (73FR68695)

Two CPT codes can no longer be used for billing partial hospitalization services: code 90849, Multi-family group psychotherapy, and 90899, Unlisted psychiatric service or procedure.

Two G codes for group therapy have been created because existing CPT group therapy codes do not capture the desired time component. These 2 new G codes are G0410, Group psychotherapy other than of a multiple-family group, in a partial hospitalization setting, approximately 45 to 50 minutes, and G0411, Interactive group psychotherapy in a partial hospitalization setting, approximately 45 to 50 minutes. CMS noted that although they generally follow CPT guidelines, there are cases where the CPT system does not meet their payer needs for code specificity, payment and timeliness of assignment, and they need to assign HCPCS codes for those services. CMS acknowledged that there may be some administrative burden for providers to bill G codes rather than CPT codes. However, they have established codes G0410 and G0411 because existing CPT group therapy codes do not capture the time component that the proposed G codes do. CMS defined these G codes according to the industry standard for group psychotherapy.

During data analysis for the CY 2009 OPPS proposed rule, CMS observed some providers incorrectly billing patient and education services using CPT code 90899, Unlisted psychiatric service or procedure. CMS clarified in the final rule that HCPCS code G0177, Training and education services related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more), is the only valid partial hospitalization code to bill patient and training education services. This code may also be used in a non- partial hospitalization setting.

XI. Procedures That Will Be Paid Only as Inpatient Procedures (73FR68698)

XI.B. Changes to the Inpatient List (73FR68699)

Twelve CPT procedure codes have been removed from the inpatient list. These codes are:

- 20660, Application of cranial tongs caliper, or stereotactic frame, including removal (separate procedure)

- 21172, Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)
- 21386, Open treatment of orbital floor blowout fracture; periorbital approach
- 21387, Open treatment of orbital floor blowout fracture; combined approach
- 27479, Arrest, epiphyseal, any method (e.g., epiphysiodesis); combined distal femur, proximal tibia and fibula
- 43420, Closure of esophagostomy or fistula; cervical approach
- 50727, Revision of urinary-cutaneous anastomosis (any type urostomy)
- 51845, Abdomino-vaginal vesical neck suspension, with or without endoscopic control (e.g., Stamey, Raz, modified Pereyra)
- 51860, Cystorrhaphy, suture of bladder wound, injury or rupture; simple
- 54332, One stage proximal penile or penoscrotal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap
- 54336, One stage perineal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap
- 54535, Orchiectomy, radical, for tumor; with abdominal exploration.

A list of these CPT codes with their final 2009 APC assignment can be found in Table 39 on page 68701 of the final rule.

XII. OPPS Nonrecurring Technical and Policy Changes and Clarifications (73FR68702)

XII.B. Reporting of Pathology Services for Prostate Saturation Biopsy (73FR68704)

Four HCPCS G codes have been created for pathology services associated with prostate saturation biopsy:G0416 (Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 1-20 specimens); G0417 (Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 21-40 specimens); G0418 (Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 41-60 specimens); and G0419 (Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, greater than 60 specimens). These G codes have been assigned to four different New Technology APCs for CY 2009. Code G0416 is assigned to APC 1505 (New Technology – Level V); code G0417 is assigned to APC 1507 (New Technology – Level VII); code G0418 is assigned to APC 1511 (New Technology – Level XI); and code G0419 is assigned to APC 1513 (New Technology – Level XIII). Each of these New Technology APCs has a status indicator of "S," indicating that there is no discount when multiple significant procedures are provided on the same day to a single Medicare beneficiary.

CPT code 88305 (Level IV – Surgical pathology, gross and microscopic examination) will continue to be recognized under the OPPS for those surgical pathology services unrelated to prostate saturation biopsy.

XII.D. Reporting of Wound Care Services (73FR68706)

CPT code 0183T (Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, would assessment, and instruction(s) for ongoing care, per day) has been designed as a "sometimes therapy" service, which is defined as a service that may be performed by an individual outside of a certified therapy plan of care. In CY 2009, hospitals will receive separate payment under the OPPS when they bill for wound care services described by CPT code 0183T that are furnished to hospital outpatients by individuals independent of a therapy plan of care. When such services are performed by a qualified therapist under a certified therapy plan of care, providers should attach an appropriate therapy modifier ("GP" for physical therapy, "GO" for occupational therapy, and "GN" for speech language pathology) or report their charges under a therapy revenue code, or both, to receive payment under the Medicare Physician Fee Schedule.

The service identified by code 0183T is assigned to APC 0015, Level III Debridement & Destruction, for payment under the OPPS if the service is not provided under a certified therapy plan of care or directs contractors to pay under the Medicare Physician Fee Schedule if the service is identified on a hospital claim with a therapy modifier or therapy revenue code as a therapy service.

XIII. OPPS Payment Status and Comment Indicators (73FR68707)

XIII.A.1. Payment Status Indicators to Designate Services that are Paid Under the OPPS (73FR68707)

Payment status indicator "Q" has been replaced with three new separate status indicators: Q1, STVX-packaged codes; Q2, T-packaged codes; and Q3, Codes that may be paid through a composite APC.

New payment status indicator "R" will be used for all blood and blood product APCs and new payment status indicator "U" will be used for brachytherapy source APCs. These new status indicators will facilitate implementation of the reduced conversion factor that would apply to payments to hospitals that are required to report quality data but that fail to meet the established quality data reporting standards.

XV. Ambulatory Surgical Centers: Updates and Revisions to the Ambulatory Surgical Center Conditions for Coverage and Updates to the Revised Ambulatory Surgical Center Payment System (73FR68712)

XV.B.2. Updates and Revisions to the ASC Conditions for Coverage – Provisions of the Proposed and Final Regulations (73FR68713)

The definition of ambulatory surgical center (ASC) has been revised to state that an ASC means any distinct entity that operates exclusively for the purpose of providing surgical services to "patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission."

XV.C.3. Policies Governing Changes to the Lists of Codes and Payment Rates for ASC Covered Surgical Procedures and Covered Ancillary Services (73FR68723)

CMS will include in their annual evaluation of procedures excluded from the ASC list of covered surgical procedures all procedures proposed for removal from the OPPS inpatient list. They will also evaluate the OPPS APCs for potential inconsistencies related to exclusion from the ASC list of covered surgical procedures.

XV.D.2. Treatment of New Level II HCPCS Codes Implemented in April and July 2008 (73FR68724)

For CY 2009, the CMS HCPCS Workgroup created permanent HCPCS J codes for the four HCPCS codes that were implemented in April 2008 and one of the codes that was implemented in July 2008, and CMS will be recognizing these HCPCS J codes for payment of these drugs and biological under the CY 2009 ASC payment system, consistent with their general policy to use permanent HCPCS codes, if appropriate, for the reporting of drugs. Tables 41 and 42 on page 68726 of the final rule show the new permanent HCPCS J codes that replace several HCPCS C codes and Q codes that have been deleted, effective December 31, 2008. The HCPCS J codes, effective January 1, 2009, describe the same drugs and the same dosages as the HCPCS codes they are replacing. Because the new HCPCS codes describe the same drugs and the same dosages as do the current codes, there is no effect on the payment indicators.

Also, a new HCPCS Q code, Q4114, which is effective January 1, 2009, was created to replace HCPCS code C9357, Dermal substitute, granulated cross-linked collagen and glycosaminoglycan matrix, (Flowable Wound Matrix), 1 cc. Although the long descriptor is changed, the new code describes the same biological and dosage as did HCPCS code C9357. HCPCS code Q4114 is recognized for payment under the CY 2009 ASC payment system, and no change to the payment indicator of the HCPCS code is warranted.

XV.E.1a. Additions to the List of ASC Covered Surgical Procedures (73FR68726)
Fourteen procedures have been added to the list of ASC covered surgical procedures. Three of the fourteen procedures are new category III CPT codes that became effective July 1, 2008 and were implemented in the July 2008 ASC update: code 0190T (Placement of intraocular radiation source applicator); code 0191T (Insertion of anterior segment aqueous drainage device, without extraocular reservoir; internal approach); and code 0192T (Insertion of anterior segment aqueous drainage device, without extraocular reservoir; external approach).

The other eleven procedures were among those excluded from the ASC list for CY 2008 because CMS believed they did not meet the definition of a covered surgical procedure based on their expectation that they would pose a significant safety risk to Medicare beneficiaries or would require an overnight stay if performed in ASCs. Based on CMS' review and comments submitted in response to the proposed rule, the following eleven procedures are no longer excluded from the ASC list:

- 15170 (Acellular dermal replacement, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children)
- 15171 (Acellular dermal replacement, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof)
- 15175 (Acellular dermal replacement, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children)
- 15176 (Acellular dermal replacement, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm or each additional 1% of body area of infants and children, or part thereof)
- 34490 (Thrombectomy, direct or with catheter; axillary and subclavian vein, by arm incision)
- 36455 (Exchange transfusion, blood; other than newborn)
- 49324 (Laparoscopy, surgical; with drainage of lymphocele to peritoneal cavity)
- 49325 (Laparoscopy, surgical; with revision of previously placed intraperitoneal cannula or catheter, with removal of intraluminal obstructive material if performed)
- 49326 (Laparoscopy, surgical; with omentopexy (omental tacking procedure))
- 64448 (Injection, anesthetic agent; femoral nerve, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration)
- 64449 (Injection, anesthetic agent; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration)

XV.E.1b. Covered Surgical Procedures Designated as Office-Based (73FR68730)
The following five CPT codes represent procedures that have been newly designated as office-based for CY 2009:

- 0084T (Insertion of a temporary prostatic urethral stent)
- 36515 (Therapeutic apheresis; with extracorporeal immunoadsorption and plasma reinfusion)
- 36516 (Therapeutic apheresis; with extracorporeal selective adsorption or selective filtration and plasma reinfusion)
- 65436 (Removal of corneal epithelium; with application of chelating agent (e.g., EDTA))
- 67505 (Retrobulbar injection; alcohol)

The office-based designation for CPT code 0084T is temporary because CMS did not have adequate data upon which to base a permanent designation.

XV.E.1c. Covered Surgical Procedures Designated as Device-Intensive (73FR68733)
CMS updated the ASC list of covered surgical procedures that are eligible for payment according to the device-intensive procedure payment methodology for CY 2009. The ASC covered surgical procedures that are designated as device-intensive for CY 2009 can be found in Table 47 on page 68736 of the final rule.

XV.E.1d. Surgical Procedures Removed From the OPPS Inpatient List for CY 2009 (73FR68738)

All of the twelve procedures removed from the OPPS inpatient list for CY 2009 are excluded from the ASC list of covered surgical procedures for CY 2009 because they may be expected to pose a significant risk to beneficiary safety in ASCs or require an overnight stay.

XVI. Reporting Quality Data for Annual Payment Rate Updates (73FR68758)

XVI.C. Quality Measures for CY 2010 and Subsequent Calendar Years and the Process to Update Measures (73FR68760)

1. Quality Measures for CY 2010 Payment Determinations (73FR68760)

CMS is finalizing for continued data collection in CY 2009 for the CY 2010 annual payment update the following seven current HOP QDRP measures, redesignated as discussed:

OP–1: Median Time to Fibrinolysis;
OP–2: Fibrinolytic Therapy Received Within 30 Minutes;
OP–3: Median Time to Transfer to Another Facility for Acute Coronary Intervention;
OP–4: Aspirin at Arrival;
OP–5: Median Time to ECG;
OP–6: Timing of Antibiotic Prophylaxis; and
OP–7: Prophylactic Antibiotic Selection for Surgical Patients.

The four imaging measures that CMS proposed to adopt beginning with the CY 2010 payment determination are claims-based measures that would be calculated using Medicare Part B claims data without imposing on hospitals the burden of additional chart abstraction. The four imaging measures for the CY 2010 payment determination:

Imaging Measures
OP–8: MRI Lumbar Spine for Low Back Pain;
OP–9: Mammography Follow-up Rate;
OP–10: Abdomen CT—Use of Contrast Material; and
OP–11: Thorax CT—Use of Contrast Material.

*Two of the measures, *OP–8: MRI Lumbar Spine for Low Back Pain and OP–11: Thorax CT—Use of Contrast Material* are NQF endorsed. The technical specifications for these four new HOP QDRP measures will be published in the January 2009 Specification Manual located at http://www.qualitynet.org.

2. Process for Updating Measures (73FR68766)

CMS proposed to establish a subregulatory process that would allow them to update the technical specifications that are used to calculate measures when it is believed such

updates are warranted based upon scientific evidence and guidance from a national consensus building entity. CMS has determined that they will be using the subregulatory process.

CMS will continue to release a HOPD Specification Manual every 6 months and addenda as necessary providing at least 3 months of advance notice for non-substantive changes such changes to ICD–9 and HCPCS codes and at least 6 months notice for substantive changes to data
elements that will require significant systems changes.

3. Possible New Quality Measures for CY 2011 and Subsequent Calendar Years (73FR68767)

CMS is considering the recommended topic areas as they continue to develop new quality measures for CY 2011.

XVI.E. Requirements for HOPD Quality Data Reporting for CY 2010 and Subsequent Calendar Years (73FR68772)

1. Administrative Requirements (73FR68772)

CMS is finalizing the administrative requirements as proposed. To participate in the HOP QDRP, several administrative steps must be completed. These steps require the hospital to:

- Identify a QualityNet administrator who follows the registration process and submits the information to the appropriate CMS designated contractor.
- Register with QualityNet regardless of the method used for data submission.
- Complete the Notice of Participation form if one has not been completed or if a hospital has
  previously submitted a withdrawal form.

2. ***Data Collection and Submission Requirements*** (73FR68773)

CMS is adopting the final rule as proposed however with some modifications. Hospitals that have five or fewer cases for any measure included in a measure topic will not be required to submit patient level data for that entire measure topic for that quarter; however, these hospitals may voluntarily submit these data. CMS is not requiring the submission of aggregate population figures, for data reported for CY 2009 in order to receive the full CY 2010 payment update, although hospitals may voluntarily submit these data.

3. HOP QDRP Validation Requirements (73FR68775)

a. ***Data Validation Requirements for CY 2010*** (73FR68775)

CMS is not finalizing the proposed validation method to be used toward CY 2010 payment decisions. CMS realizes the need for hospitals to gain experience with any

validation process for HOP QDRP data collection. In light of the public comments received, CMS is conducting a voluntary test validation program in CY 2009, the results of which will not affect the CY 2010 payment update for any hospital.

F. Publication of HOP QDRP Data (73FR68777)

CMS is finalizing their proposal that hospitals sharing the same CMS Certification Number (CCN) must combine data collection and submission across their multiple campuses for all HOP QDRP measures. CMS is also finalizing their proposal to publicly report HOP QDRP measures by CCN with notation on the Web site where the publicly reported measures combine results from two or more hospitals.

H. Reporting of ASC Quality Data (73FR68779)

Reporting of ASC quality data will not be required and will continue to be considered for future rulemaking.

I. FY 2010 IPPS Quality Measures Under the RHQDAPU Program (73FR68780)

CMS has received endorsement from NQF for the following two measures that were proposed in the FY 2009 IPPS final rule:

PROPOSED QUALITY MEASURES TO BE FINALIZED IN THE CY 2009 OPPS/ASC FINAL RULE WITH COMMENT PERIOD
[Contingent on endorsement by national consensus-building entity]

Readmission Measures (Medicare Patients) • AMI 30–Day Risk Standardized Readmission Measure (Medicare patients). • Pneumonia (PN) 30–Day Risk Standardized Readmission Measure (Medicare patients).

These measures will be included in the CY 2010 RHQDAPU program measure set.

XVII. Healthcare-Associated Conditions (FR7368781)

XVII.B. Expanding the Principles of the IPPS Hospital-Acquired Conditions Payment Provision to the OPPS (73FR68781)

CMS believes the principle of Medicare not paying for the preventable hospital-acquired conditions during inpatient stays paid under the hospital inpatient prospective payment system could be applied to the hospital outpatient department setting. Given that so much medical care is now provided to Medicare beneficiaries outside of the hospital inpatient setting, CMS believes that extending a healthcare-associated conditions payment policy to the OPPS is an important and essential next step in Medicare's focus on quality and value.

CMS looks forward to working with the National Uniform Billing Committee to develop Present on Admission (POA) indicators appropriate to outpatient settings. As CMS moves toward an OPPS healthcare-associated conditions payment policy, they will work with hospitals and other stakeholders to ensure that reporting of conditions in outpatient settings could be accomplished in a way that would be administratively manageable for

hospitals, while discouraging potential undesirable effects on beneficiaries and the Medicare program, such as overutilization of diagnostic testing.

CMS views addressing the ongoing problem of preventable healthcare-associated conditions in outpatient settings, including the hospital outpatient department, as a key value-based purchasing strategy to sharpen the focus on such improvements beyond hospital inpatient care to those settings where the majority of Medicare beneficiaries receive most of their healthcare services.