

# **Analysis of Final Rule for 2008 Revisions to the Medicare Hospital Outpatient Prospective Payment System**

The final rule for calendar year (CY) 2008 revisions to the Medicare Hospital Outpatient Prospective Payment System (OPPS) was published in the *Federal Register* on November 27, 2007. This rule becomes effective for services rendered on or after January 1, 2008.

This analysis will cover highlights of the revisions to the HOPPS that are considered to be of particular interest to 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* and can be accessed at: <http://a257.g.akamaitech.net/7/257/2422/01jan20071800/edocket.access.gpo.gov/2007/pdf/07-5507.pdf>.

## **II. Updates Affecting OPPS Payments (page 66588)**

### ***II.A.4. Changes to Packaged Services (page 66610)***

For hospital outpatient services, the volume and intensity of services are estimated to have continued to increase significantly in recent years, at a rate of 10.1 percent between CY 2005 and CY 2006. Creating additional incentives for providing only necessary services in the most efficient manner is of vital importance to Medicare today, in view of the recent explosion of growth in program expenditures for hospital outpatient services paid under the OPPS. The rapid growth in utilization of services under the OPPS shows that Medicare is paying mainly for more services each year, regardless of their quality or impact on beneficiary health. The Medicare Payment Advisory Commission (MedPAC) found that while the rate of growth in service volume declined, the complexity of services, defined as the sum of the relative payment weights of all OPPS services divided by the volume of all services, increased, and that most of the growth was attributable to the insertion of devices and the provision of complex imaging services. MedPAC further found that regression analysis suggested that relatively complex hospital outpatient services may be more profitable than less complex services. They also found that favorable payments for complex services give hospitals an incentive to provide more of those complex services rather than fewer basic services, which increases overall service complexity. In the future, MedPAC plans to examine options for recalibrating the payment system to accurately match payments to the costs of individual services.

As the next step in the movement toward value-based purchasing under the OPPS and to complement the Hospital Outpatient Quality Data Reporting Program (HOP QDRP) for CY 2009, with measure reporting beginning in CY 2008, the Centers for Medicare & Medicaid Services (CMS) believe it is important to initiate specific payment approaches to explicitly encourage efficiency in the hospital outpatient setting that they believe will control future growth in the volume of OPPS services. While the HOP QDRP will encourage the provision of higher quality hospital outpatient services that lead to

improved health outcomes for Medicare beneficiaries, CMS believes that more targeted approaches are also necessary to encourage increased hospital efficiency. CMS believes that increased packaging and bundling are the most appropriate payment strategies to establish incentives for hospitals to monitor and adjust the volume and efficiency of their services.

MedPAC intends to perform a long-term assessment of the design of the OPSS, including considering the bundling of payments for procedures and visits furnished over a period of time into a single payment, assessing whether there should be an expenditure target for hospital outpatient services, evaluating whether payments for multiple imaging services provided in the same session should be discounted, and reviewing the methodology used by CMS to determine relative payment weights for hospital outpatient services.

Because CMS believes it is important that the OPSS create enhanced incentives for hospitals to provide only necessary, high quality care and to provide that care as efficiently as possible, they have given considerable thought to how they could increase packaging under the OPSS in a manner that would not place hospitals at substantial financial risk but which would create incentives for efficiency and volume control, while providing hospitals with flexibility to provide care in the most appropriate way for each Medicare beneficiary. CMS is considering the possibility of greater bundling of payment for major hospital outpatient services, which could result in establishing OPSS payments for episodes of care.

CMS is currently considering the complex policy issues related to the possible development and implementation of a bundled payment policy for hospital outpatient services that involves significant services provided over a period of time, which could be paid through an episode-based payment methodology, but this possible approach is considered to be a long-term policy objective.

CMS is also examining how they might possibly establish payments for same-day care encounters, building upon the current use of Ambulatory Payment Classifications (APCs) for payment through greater packaging of supportive ancillary services. This could include conditional packaging of supportive ancillary services into payment for the procedure that is the reason for the OPSS encounter (for example, diagnostic tests performed on the day of a scheduled procedure). Another approach could include creation of composite APCs for frequently performed combinations of surgical procedures (for example, one APC payment for multiple cardiac electrophysiologic procedures performed on the same date).

CMS intends to involve the APC Panel in their future exploration of how they can develop encounter-based and episode-based payment groups. This is a significant change in direction for the OPSS, and they are seeking the recommendations of all stakeholders with regard to which ancillary services could be packaged and those combinations of services provided in a single encounter or over time that could be bundled together for payment.

**II.A.4.c. Packaging Approach** (page 66614)

As an initial substantial step toward creating larger payment groups for hospital outpatient care, CMS has decided to package payment for items and services in certain categories of HCPCS codes that are typically ancillary and supportive to a primary diagnostic or therapeutic modality and, in those cases, are an integral part of the primary service they support. Table 10 in the final rule (page 66659) contains a comprehensive list of all codes in the final seven categories for which CMS will package payment either unconditionally (to which status indicator “N” is assigned) or conditionally, providing separate payment if certain criteria are met (to which status indicator “Q” is assigned). There is a category of conditionally packaged codes assigned status indicator “Q” which was previously referred to as “special” packaged codes because their payment was packaged when provided on the same date as a service that was assigned status indicator “S,” “T,” “V,” or “X.” These “special” packaged codes are now referred to as “STVX-packaged codes.” There is a new category of conditionally packaged codes, called “T-packaged codes,” whose payment is packaged when provided on the same date as another service that is assigned status indicator “T.”

The seven packaging categories are:

- **Guidance Services**  
For CY 2008, all guidance services, including radiation oncology services, are packaged.
- **Image Processing Services**  
Payment for “image processing” HCPCS codes has been packaged (specifically, those codes that are reported as supportive dependent services to process and integrate diagnostic test data in the development of images, performed concurrently or after the independent service is complete).
- **Intraoperative Services**  
Payment for “intraoperative” HCPCS codes is packaged for CY 2008 (specifically, those codes that are reported for supportive dependent diagnostic testing or other minor procedures performed during independent procedures).

The status indicator for CPT code 0126T, Common carotid intima-media thickness (IMT) study for evaluation of atherosclerotic burden or coronary heart disease risk factor assessment, has been changed from unconditionally packaged to conditionally packaged (status indicator “Q”). CMS believes that this procedure would usually be provided by a hospital in conjunction with another independent procedure on the same date of service, but may occasionally be provided without another independent service.

- **Imaging Supervision and Interpretation Services**  
The status indicator for a number of codes for imaging supervision and interpretation services has been changed from separately paid to unconditionally or conditionally packaged. The conditionally packaged imaging supervision and interpretation services are specific to surgical procedures and are called “T-

packaged services.” The payment for these imaging supervision and interpretation services is now packaged into the payment for services with a status indicator “T” when they appear on the same date as the surgical procedure. When these imaging supervision and interpretation services appear with other codes that have any other payable status indicator (S, V, or X) or with other services that have a status indicator “Q” on the same date, one unit of the T-packaged service with the highest relative payment weight would be paid.

- **Diagnostic Pharmaceuticals**

For CY 2008, diagnostic radiopharmaceuticals have been packaged.

- **Contrast Agents**

Payment for all contrast media has been packaged into their associated independent diagnostic and therapeutic procedures. APC 0128 (Echocardiogram with Contrast) has been created to provide payment for echocardiography procedures that are performed with a contrast agent in CY 2008. In order for hospitals to report echocardiography procedures performed with contrast, as all contrast will be packaged in CY 2008, eight new level II HCPCS codes for echocardiography with contrast have been created.

- **Observation Services**

For CY 2008, payment for observation care is packaged as part of the payment for the separately payable services with which it is billed. Two composite APCs that will provide payment to hospitals in certain circumstances when extended assessment and management of a patient occur have been created. These APCs are APC 8002 (Level I Extended Assessment and Management Composite) and APC 8003 (Level II Extended Assessment and Management Composite). APC 8002 describes an encounter for care provided to a patient that includes a high level (Level 5) clinic visit or direct admission to observation in conjunction with observation services of substantial duration. APC 8003 describes an encounter for care provided to a patient that includes a high level (Level 4 or 5) emergency department visit or critical care services in conjunction with observation services of substantial duration.

APC 8002 will be assigned when 8 or more units of HCPCS code G0378, Hospital observation services, per hour, are billed:

- On the same day as HCPCS code G0379, Direct admission of patient for hospital observation care; or
- On the same day or the day after –
  - CPT code 99205, Office or other outpatient visit for the evaluation and management of a new patient (Level 5); or
  - CPT code 99215, Office or other outpatient visit for the evaluation and management of an established patient (Level 5).

If a hospital provides a service with status indicator “T” on the same date of service, or one day earlier than the date of service associated with code G0378, the hospital will not be eligible for payment under APC 8002. There is no

diagnosis requirement for purposes of this composite APC. Patients with any diagnosis may trigger payment of APC 8002. If any of the criteria listed above are not met, payment would not be made through APC 8002. Instead, payment for any separately payable services, including the clinic visit, would be made through the usual associated APCs. Payment for a direct admission to observation would be made according to the usual code G0379 payment criteria and payment for code G0378 would remain packaged because the observation care is considered to be supportive and ancillary to whichever service(s) it accompanies.

APC 8003 will be assigned when eight or more units of code G0378 are billed on the same day or the day after code 99284, Emergency department visit for the evaluation and management of a patient (Level 4), 99285, Emergency department visit for the evaluation and management of a patient (Level 5), or 99291, Critical care, evaluation and management of the critically ill or critically injured patient, first 30-74 minutes. The remaining criteria are identical to the criteria associated with composite APC 8002. There is no diagnosis requirement for purposes of this APC, either. If a hospital provides a service with status indicator “T” on the same date of service, or one day earlier than the date of service associated with code G0378, the composite APC 8003 would not apply. Instead, payment for the emergency department visit or critical care and any other separately payable services will be made through the usual associated APCs, and payment for code G0378 for observation services will remain packaged because CMS considers the observation care to be supportive and ancillary to whichever service(s) it accompanies.

Code G0378 will continue to be assigned status indicator “N,” signifying that its payment is always packaged. In most circumstances, observation services are supportive and ancillary to the other services provided to the patient. In the circumstances when observation care is elevated to a major component service in conjunction with a high level visit or direct admission that is an integral part of a patient’s extended encounter for care, payment is made for the entire care encounter through APC 8002 or 8003, as appropriate.

The previous criteria related to physician order and evaluation, documentation, and observation beginning and ending time are being retained as general reporting requirements for all observation services.

#### **II.A.4.d. Development of Composite APCs** (page 66650)

APC 8001, LDR Prostate Brachytherapy Composite, has been created and will provide one bundled payment for low dose rate (LDR) prostate brachytherapy when the hospital bills both codes 55875 (Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy) and 77778 (Interstitial radiation source application; complex) as component services provided during the same hospital encounter.

APC 8000, Cardiac Electrophysiologic Evaluation and Ablation Composite, has been created in order to pay for a composite service comprised of combinations of codes for cardiac electrophysiologic evaluation and ablation procedures. Hospitals should continue to code using CPT codes to report these services and the Outpatient Code Editor will recognize when the criteria for payment of the composite APC are met and would assign the composite APC instead of the single procedure APCs.

Codes in composite APCs, including the two extended assessment and management APCs, are displayed in Addendum M in the final rule (page 67224).

### **III. OPSS Ambulatory Payment Classification (APC) Group Policies** (page 66688)

#### ***III.A.2. Treatment of New Category I and III CPT Codes and Level II HCPCS Codes*** (Page 66690)

Effective for January 1, 2008, eight HCPCS C-codes have been created that describe transthoracic echocardiography with contrast and transesophageal echocardiography with contrast.

#### ***III.C.2. Movement of Procedures from New Technology APCs to Clinical APCs*** (page 66694)

CPT code 19298, Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes imaging guidance, from New Technology APC 1524 to APC 0648 (Level IV Breast Surgery).

HCPCS codes G0302, Preoperative pulmonary surgery services for preparation for lung volume reduction surgery, complete course of services, to include a minimum of 16 days of services, and G0303, Preoperative pulmonary surgery services for preparation for lung volume reduction surgery, 10 to 15 days of services, have been reassigned to APC 0209 (Level II Extended EEG and Sleep Studies). These codes were previously assigned to APCs 1509 and 1507, respectively.

HCPCS codes G0304, Preoperative pulmonary surgery services for preparation for lung volume reduction studies, 1 to 9 days of services, and G0305, Post-discharge pulmonary surgery services after lung volume reduction surgery, minimum of 6 days of services, have been reassigned to APC 0213 (Level I Extended EEG and Sleep Studies). These codes were previously assigned to APC 1504.

#### ***III.D.1. Cardiac Procedures*** (page 66699)

The codes for cardiac computed tomography and computed tomographic angiography (codes 0144T through 0151T) have been reassigned from their interim APC assignments

to APC 0282 (Miscellaneous Computerized Axial Tomography) and new APC 0383 (Cardiac Computed Tomographic Imaging).

APC 0081 (Noncoronary Angioplasty or Atherectomy) has been deleted, and the procedures that mapped to this APC in CY 2007 have been reassigned to APCs 0082 (Coronary or Non-Coronary Atherectomy), 0083 (Coronary or Non-Coronary Angioplasty and Percutaneous Valvuloplasty), and 0103 (Miscellaneous Vascular Procedures).

The Level II HCPCS codes for insertion of implantable cardioverter-defibrillators have been deleted. Hospitals should report the appropriate CPT codes (33240, 33249) for these procedures, along with the applicable device C-codes.

Code 33284, Removal of an implantable, patient-activated cardiac event recorder, has been reassigned from APC 0109 (Removal/Repair of Implanted Devices) to APC 0020 (Level II Excision/Biopsy).

APC 0082 has been reconfigured by adding 11 CPT codes, most of which are for percutaneous atherectomy procedures, and to change the title to “Coronary or Non-Coronary Atherectomy.”

### ***III.D.2. Gastrointestinal Procedures*** (page 66705)

Diagnostic computed tomographic colonography (code 0067T) has been reassigned from APC 0333 (Computed Tomography without Contrast followed by Contrast) to APC 0332 (Computed Tomography without Contrast).

Code 43647 (Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum) has been reassigned from APC 0130 (Level 1 Laparoscopy) to APC 0061 (Laminectomy or Incision for Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve).

### ***III.D.3. Genitourinary Procedures*** (page 66707)

New CPT code 50593, Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy, has been assigned to APC 0423 (Level II Percutaneous Abdominal and Biliary Procedures). Its predecessor code, 0135T, had been assigned to APC 0163 (Level IV Cystourethroscopy and other Genitourinary Procedures). As with the predecessor code, both the CPT procedure code and the HCPCS device code (C2618) should be reported.

Codes 53850 (Transurethral destruction of prostate tissue; by microwave thermotherapy) and 53852 (Transurethral destruction of prostate tissue; by radiofrequency thermotherapy) have been reassigned from APC 0675 (Prostatic Thermotherapy) to APC 0429 (Level V Cystourethroscopy and other Genitourinary Procedures).

APC 0675 (Prostatic Thermotherapy) has been deleted. One of the codes that mapped to this APC, 53850 (Transurethral destruction of prostate tissue; by microwave thermotherapy), has been reassigned to APC 0163 (Level IV Cystourethroscopy and

other Genitourinary Procedures). The other code that mapped to this APC, 53852 (Transurethral destruction of prostate tissue; by radiofrequency thermotherapy) has been reassigned to APC 0429 (Level V Cystourethroscopy and other Genitourinary Procedures).

Codes 0071T (Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume less than 200 cc of tissue) and 0072T (Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume greater or equal to 200 cc of tissue) have been reassigned from APCs 0195 (Level IX Female Reproductive Proc) and 0202 (Level X Female Reproductive Proc) to APC 0067 (Level III Stereotactic Radiosurgery, MRgFUS, and MEG).

#### ***III.D.4. Nervous System Procedures*** (page 66712)

APC 0223 (Implantation or Revision of Pain Management Catheter) has been deleted. Code 62350 (Implantation, revision, or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy) has been reassigned to APC 0224 (Implantation of catheter/reservoir/shunt).

The APC assignments of procedures involving implantation of neurostimulators have been reconfigured in order to improve the resource homogeneity of these APCs and ensure appropriate payment for both rechargeable and nonrechargeable neurostimulators. The revised APC configuration groups payment for certain procedures mainly involving nonrechargeable neurostimulator technology (cranial, sacral, gastric, or other peripheral neurostimulators) into two clinical APCs (APCs 0039 and 0315), while establishing a single APC for spinal neurostimulator implantation, which may commonly utilize either rechargeable or nonrechargeable technologies (APC 0222). Specifically, CMS has reassigned code 64590 for implantation of peripheral neurostimulators from APC 0222 to APC 0039, which already includes code 61885 for implantation of single array cranial neurostimulators. Code 63685 for the implantation of spinal neurostimulators is the only code remaining in APC 0222.

This APC reconfiguration does not affect CPT code assignment to APC 0315 (Level II Implantation of Neurostimulators), which will continue to include only code 61886 (Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to two or more electrode arrays), although all three APCs have been renamed to accommodate the new configuration. CMS believes the revised APC configuration best serves the principles of a prospective payment system by following their standard practice of retaining a single CPT code for neurostimulator implantation procedures that does not distinguish between the implantation of rechargeable and nonrechargeable neurostimulators, into which the costs of both types of devices are packaged in relationship to their OPPS utilization. The changes do not require hospitals to alter their coding practices in any way to conform to the new payment policy.

#### ***III.D.5. Nuclear Medicine and Radiation Oncology Procedures*** (page 66716)

Code 78075, Adrenal imaging, cortex and/or medulla, has been reassigned from APC 0391 (Level II Endocrine Imaging) to APC 0408 (Level III Tumor/Infection Imaging).

Code 38792 (Injection procedure; for identification of sentinel node) has been reassigned from APC 0389 (Level I Non-imaging Nuclear Medicine) to APC 0392 (Level II Non-imaging Nuclear Medicine).

#### ***III.D.6. Ocular and Ear, Nose, and Throat Procedures*** (page 66720)

HCPCS code V2790, Amniotic membrane for surgical reconstruction, per procedure, has been assigned status indicator “N” (packaged) for CY 2008. The related CPT procedure codes have been assigned to APC 0244 (Corneal Transplant). The title of this APC has been changed to “Corneal and Amniotic Membrane Transplant.”

#### ***III.D.7. Orthopedic Procedures*** (page 66722)

For CY 2008, eleven arthroscopic procedures that were previously in APC 0041 (Level I Arthroscopy) have been reassigned to APC 0042 (Level II Arthroscopy). Three arthroscopic procedures that were previously in APC 0053 (Level I Hand Musculoskeletal Procedures) have been reassigned to APC 0041. Table 21 on page 66722 of the final rule lists the CPT codes for arthroscopic procedures that have been reassigned to different APCs.

The following codes have been assigned to APC 0052 (Level IV Musculoskeletal Procedures Except Hand and Foot): 22523 (Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); thoracic), 22524 (Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); lumbar), and 22525 (Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure).

#### ***III.D.8. Vascular Procedures*** (page 66725)

Code 36566 (Insertion of tunneled centrally inserted central venous access device, requiring two catheters via two separate venous access sites; with subcutaneous port(s)), has been assigned to APC 0625 (Level IV Vascular Access Procedures), as the only code in that APC.

#### ***III.D.9. Other Procedures*** (page 66728)

The four CY 2007 skin repair APCs have been deleted and replaced with five new APCs: APC 0133 (Level I Skin Repair), APC 0134 (Level II Skin Repair), APC 0135 (Level III

Skin Repair), APC 0136 (Level IV Skin Repair), and APC 0137 (Level V Skin Repair). Each of the procedures assigned to the four CY 2007 skin repair APCs has been redistributed into the five new APCs, with one exception. Code 15835 (Excision, excessive skin and subcutaneous tissue (including lipectomy); buttock) has been reassigned to APC 0022 (Level IV, Excision/Biopsy). The redistribution of the CPT codes into the new skin repair APCs can be found in Table 22 on page 66732 of the final rule.

#### ***III.D.10. Medical Services*** (page 66737)

CPT code 95250 (Ambulatory continuous glucose monitoring of interstitial fluid via a subcutaneous sensor for up to 72 hours; sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording) has been reassigned from APC 0421 (Prolonged Physiologic Monitoring) to APC 0607 (Level 4 Hospital Clinic Visits). APC 0421 has been deleted.

The following HCPCS codes have been reassigned from APC 0421 to APC 0607: G0248 (Demonstration at initial use, of home INR monitoring for patient with mechanical heart valve(s) who meets Medicare coverage criteria, under the direction of a physician; includes: demonstrating use and care of the INR monitor, obtaining at least one blood sample, provision of instructions for reporting home INR test results, and documentation of patient ability to perform testing) and G0249 (Provision of test materials and equipment for home INR monitoring to patient with mechanical heart valve(s) who meets Medicare coverage criteria; includes provision of materials for use in the home and reporting of test results to physician; per 4 tests).

CPT code 90862 (Pharmacologic management, including prescription, use, and review of medication with no more than minimal psychotherapy) and HCPCS code M0064 (Brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental psychoneurotic and personality disorders) have been reassigned from APC 0374 (Monitoring Psychiatric Drugs) to APC 0606 (Level 3 Hospital Clinic Visits). APC 0374 has been discontinued for CY 2008.

### **IV. OPPTS Payment for Devices** (page 66739)

#### ***IV.A.3. Payment When Devices are Replaced with Partial Credit to the Hospital*** (page 66743)

APC 0625 (Level IV Vascular Access Procedures) has been added to the list of APCs to be adjusted in cases of full or partial credit for replaced devices. The device described by device code C1881 (Dialysis access system (implantable) that is implanted in a procedure assigned to APC 0625 has been added to the list of devices in which this policy (regarding a payment adjustment when devices are replaced with full or partial credit) applies. APC 0229 (Transcatheter Placement of Intravascular Shunts) has been deleted from the list of APCs to which the no cost or full and partial credit reduction policies would be applicable for CY 2008.

HCPCS modifier “FC” has been created to identify cases in which the hospital receives a partial credit toward the replacement of a medical device. Modifier “FC” should be appended to the HCPCS code for the procedure in which the device was inserted on claims when the device that was replaced with partial credit under warranty, recall, or field action is one of the devices listed in Table 26 in the final rule (page 66749). Hospitals should not append this modifier to the HCPCS procedure code if the device is not listed in Table 26. Claims containing the “FC” modifier will not be accepted unless the modifier is on a procedure code with status indicator “S,” “T,” “V,” or “X.” Hospitals have the option of either: (1) Submitting the claims immediately without the HCPCS modifier signifying partial credit for a replacement device and submitting a claim adjustment with the HCPCS modifier at a later date once the credit determination is made; or (2) holding the claim until a determination is made on the level of credit.

Modifier “FB” will continue to be reported when the device was replaced without cost or with a full credit for the cost of the device being replaced.

## **V. OPSS Payment Changes for Drugs, Biologicals, and Radiopharmaceuticals** (page 66752)

### ***V.B.3. Payment for Drugs and Biologicals Without Pass Through Status That Are Not Packaged*** (page 66759)

All HCPCS codes for drugs can now be reported by hospitals. Any HCPCS code for a Part B drug that is covered under the OPSS can be reported, regardless of the unit determination in the HCPCS code descriptor.

## **VIII. OPSS Drug Administration Coding and Payment** (page 66787)

### ***VIII.B. Coding and Payment for Drug Administration Services*** (page 66787)

All active CY 2008 CPT codes for drug administration services are now recognized under the OPSS.

## **IX. Hospital Coding and Payments for Visits** (page 66789)

### ***IX.B.1. Clinic Visits: New and Established Patient Visits and Consultations*** (page 66790)

For CY 2007, CMS instructed hospitals to use the CY 2007 CPT codes, as well as six HCPCS codes that became effective January 1, 2007, to report clinic and emergency department visits and critical care services on claims paid under the OPSS. These codes are unchanged for CY 2008. At this time, hospitals should continue to distinguish between new and established patient visits. For CY 2008, the CPT codes for new and established visits will continue to be payable under the OPSS, but CMS will reconsider in

the future whether there should be a distinction between new and established patient visits as they continue to work on developing national guidelines. In the meantime, CMS will assign these clinic visits to different levels of Clinic Visit APCs based on the costs they observe from historical hospital claims data.

Status indicator “B” has been assigned to the consultation codes (that is, not paid under the OPPS). Hospitals should bill a new or established visit code instead of an office consultation code. As appropriate, hospitals can build consultation services into their internal hospital guidelines related to reporting clinic visit levels, based on the complexity and resources used for these visits.

### ***IX.C.3. Visit Guidelines*** (page 66802)

In preparation for the CY 2008 OPPS/ASC proposed rule, CMS performed data analyses with the goal of studying the current and historical distribution of each level of clinic and emergency department visit codes billed nationally, as well as the distribution among various classes of hospitals. They analyzed frequency data from claims with dates of service from March 1, 2002 through December 31, 2006, including those claims that were processed through December 31, 2006.

The clinic visit data revealed a fairly normal national distribution of clinic visits, with the curve somewhat skewed to the left, consistent with the previous analysis of these data in CY 2002. The visit distributions were quite stable over the past five years. Hospitals, on average, were billing all five levels of visit codes with varying frequency, in a consistent pattern over time.

CMS noted that, in general, billing a visit in addition to another service merely because the patient interacted with hospital staff or spent time in a room for that service would be inappropriate. If a visit and another service were both billed, such as chemotherapy, a diagnostic test, or a surgical procedure, the visit should be separately identifiable from the other service because the resources used to provide nonvisit services, including staff time, equipment, and supplies, among others, were captured in the line item for that service. CMS believes that hospitals by and large are abiding by this guidance because more than 90 percent of the CY 2006 claims for Level 1 established patient visits available for the CY 2008 OPPS/ASC proposed rule were single claims.

The national emergency department visit data similarly revealed a normal national distribution of emergency department visit levels that was even more symmetrical than the national clinic visit distribution. The national distributions for emergency department visits were also stable over the past 5 years.

National guidelines have not been implemented for CY 2008. CMS acknowledged that it would be desirable to many hospitals to have one set of national guidelines. However, they also understand that it would be disruptive to other hospitals that have successfully adopted internal guidelines to implement any new set of national guidelines, while CMS addressed the problems that would be inevitable in the case of any new set of guidelines that would be applied by thousands of hospitals. Creating national guidelines has proven

more difficult than initially anticipated, and some hospitals have expressed significant concerns about virtually all of the models CMS has discussed. Until national guidelines are established, hospitals should continue using their own internal guidelines to determine the appropriate reporting of different levels of clinic and emergency department visits. CMS would not expect individual hospitals to necessarily experience a normal distribution of visit levels across their claims, although they would expect a normal distribution across all hospitals as currently observed and as would be expected if national guidelines were implemented.

Based on CMS' analyses, both clinic and emergency department national visit distributions appear normal and relatively stable over time, indicating that hospitals as a whole are billing the full range of visit codes in an appropriate manner. Similar distributions were noted for subclasses of hospitals. CMS will continue to work on national guidelines, and they continue to encourage comments and submission of successful models.

In the absence of national guidelines, CMS will continue to regularly reevaluate 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. CMS expects hospitals' internal guidelines to comport with these principles (the last five are new for CY 2008):

1. The coding guidelines should follow the intent of the CPT code descriptor in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the code.
2. The coding guidelines should be based on hospital facility resources. The guidelines should not be based on physician resources.
3. The coding guidelines should be clear to facilitate accurate payments and be usable for compliance purposes and audits.
4. The coding guidelines should meet the HIPAA requirements.
5. The coding guidelines should only require documentation that is clinically necessary for patient care.
6. The coding guidelines should not facilitate upcoding or gaming.
7. The coding guidelines should be written or recorded, well-documented, and provide the basis for selection of a specific code.
8. The coding guidelines should be applied consistently across patients in the clinic or emergency department to which they apply.
9. The coding guidelines should not change with great frequency.
10. The coding guidelines should be readily available for fiscal intermediary (or, if applicable, Medicare Administrative Contractor) review.
11. The coding guidelines should result in coding decisions that could be verified by other hospital staff, as well as outside sources.

CMS agreed with commenters that it could be useful for the American Medical Association (AMA) to publish these principles in order to clarify that it is appropriate for hospitals to apply different guidelines than physicians' guidelines to report visits provided in hospital outpatient departments. They encouraged interested parties to

contact the AMA to determine whether there is an appropriate forum to publish these principles, so that they are broadly distributed and readily available.

CMS provided clarification of some of the principles. The first principle states that coding guidelines should follow the intent of the CPT code descriptor to relate the intensity of resources to different levels of effort represented by the code, not that the hospital's guidelines need to specifically consider the three factors included in the CPT E/M codes for consideration regarding physician visit reporting.

Regarding principle 2, hospitals are responsible for reporting the CPT E/M visit code that appropriately represents the resources utilized by the hospital, rather than the resources utilized by the physician. This does not preclude a hospital from using or adapting the physician guidelines if the hospital believes that such guidelines adequately describe hospital resources.

Regarding principle 8, a hospital with multiple clinics (for example, primary care, oncology, wound care, etc.) may have different coding guidelines for each clinic, but the guidelines must be applied uniformly within each separate clinic. The hospital's assorted set of internal guidelines must measure resource use in a relative manner, in relation to each other. For example, the hospital resources required for a Level 3 established patient visit under one set of guidelines should be comparable to the resources required for a Level 3 established patient visit under all other sets of clinic visit guidelines used by the hospital.

Regarding principle 9, CMS would generally expect hospitals to adjust their guidelines less frequently than every few months and they believe it would be reasonable for hospitals to adjust their guidelines annually, if necessary.

Regarding principle 10, hospitals should use their judgment to ensure that coding guidelines are readily available, in an appropriate and reasonable format. CMS would encourage fiscal intermediaries and Medicare Administrative Contractors to review a hospital's internal guidelines when an audit occurs.

Regarding principle 11, hospitals should use their judgment to ensure that their coding guidelines can produce results that are reproducible by others.

In the absence of national visit guidelines, hospitals have the flexibility to determine whether or not to include separately payable services as a proxy to measure hospital resource use that is not associated with those separately payable services. The costs of hospital resource use associated with those separately payable services would be paid through separate OPSS payment for the other services.

#### Critical Care

CMS indicated that they had received a number of requests to allow hospitals to bill critical care without a minimum time requirement or with a time requirement of 15 minutes. The hospital may have its greatest resource use in the first 10 minutes of critical care, much earlier than the 30-minute minimum required in the code descriptor. The CPT

instructions for reporting of critical care services with CPT code 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes) and the CPT code descriptor specify that the code can only be billed if 30 minutes or more of critical care services are provided. Because hospitals will be reporting CPT codes for critical care services for CY 2008, they must continue to provide a minimum of 30 minutes of critical care services in order to bill CPT code 99291. However, hospitals can report the appropriate clinic or emergency department visit code consistent with their internal guidelines if fewer than 30 minutes of critical care is provided.

## **XI. OPSS Payment for Observation Services** (page 66810)

### ***XI.A. Observation Services (HCPCS Code G0378)*** (page 66810)

Observation services have been packaged and payment will be provided through a composite APC methodology when certain criteria apply. These composite APCs are for extended assessment and management, of which observation care is a component. The Outpatient Code Editor will determine the payment for observation as packaged into a composite APC payment or packaged into payment for other separately payable services provided in the encounter. HCPCS code G0378, Hospital observation services, per hour, has been assigned a status indicator “N,” meaning that its payment will always be packaged, either into one of the two composite APCs or, when the composite criteria are not met, into the payment for the major services on the claim. A qualifying diagnosis is no longer required, but, for the purpose of composite APC payment, all other criteria required in CY 2007 for separate observation care payment has been retained, including: a minimum number of 8 hours; a qualifying visit, direct admission to observation care, or critical care; and no “T” status procedure reported on the day before or day of observation services. The general reporting requirements for observation services have also been retained. These are the requirements related to the physician order and evaluation, documentation, and observation beginning and ending times.

### ***XI.B. Direct Admission to Observation (HCPCS Code G0379)*** (page 66814)

Payment for direct admission to observation will be made either under composite APC 8002 (Level I Prolonged Assessment and Management Composite) or under APC 0604 (Level 1 Hospital Clinic Visits). The composite APC will apply, regardless of the patient’s particular clinical condition, if the hours of observation services (HCPCS code G0378) are greater than or equal to eight and billed on the same day as HCPCS code G0378 and there is not a “T” status procedure on the same date or day before the date of HCPCS code G0378. If the composite APC is not applicable, payment for HCPCS code G0379, Direct admission of patient for hospital observation care, may be made under APC 0604. In general, this would occur when the units of observation reported under HCPCS code G0378 are less than eight and no services with a status indicator “T” or “V” or Critical Care (APC 0617) were provided on the same day of service as HCPCS code G0379. The criteria for payment of HCPCS code G0379 under APC 0604 will be the

same as in CY 2007. In cases where the criteria for payment under either APC are not met, HCPCS code G0379 is assigned status indicator “N.”

## **XII. Procedures That Will Be Paid Only as Inpatient Procedures** (page 66815)

### ***XII.B. Changes to the Inpatient List*** (page 66815)

Thirteen procedures have been removed from the OPPS inpatient list for CY 2008 and they have been assigned to clinically appropriate APCs. The CPT codes that have been removed from the inpatient list and the APCs to which they have been assigned can be found in Table 46 in the final rule (page 66816).

## **XIII. Nonrecurring Technical and Policy Changes** (page 66817)

### ***XIII.E. Reporting of Cardiac Rehabilitation Services*** (page 66820)

CPT codes 93797 and 93798 will continue to be used to report cardiac rehabilitation services under the CY 2008 OPPS. Beginning in CY 2008, CMS will allow hospitals to report more than one unit of service per day if more than one cardiac rehabilitation session lasting at least 1 hour each is provided on the same day, but they will monitor the claims data to ensure that utilization of cardiac rehabilitation services remains appropriate.

### ***XIII.F. Reporting of Bone Marrow and Stem Cell Processing Services*** (page 66821)

The use of HCPCS codes G0265, Cryopreservation, freezing and storage of cells for therapeutic use, G0266, Thawing and expansion of frozen cells for therapeutic use, and G0267, Bone marrow or peripheral stem cell harvest, modification or treatment to eliminate cell type(s) for depletion services for hematopoietic progenitor cells), have been discontinued. Instead, CPT codes 38207 through 38215 will be used to report bone marrow and stem cell processing services under the OPPS. CPT codes 38207, 38208, and 38209 for cryopreserving, thawing and washing bone marrow cells have been assigned to APC 0110 (Transfusion). CPT codes 38210 through 38215, reported for depletion services of bone marrow and stem cells, have been assigned to APC 0393, which has been renamed “Hematologic Processing and Studies.”

### ***XIII.G. Reporting of Alcohol and/or Substance Abuse Assessment and Intervention Services*** (page 66823)

For CY 2008, the CPT Editorial Panel has created two new category I CPT codes for reporting alcohol and/or substance abuse screening. They are CPT codes 99408 (Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes) and 99409 (Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes). The code descriptions for

these codes suggest that they may describe services that include screening services. Screening services are not covered by Medicare without specific statutory authority, such as has been provided for mammography, diabetes, and colorectal cancer screening. Therefore, CMS will not recognize these CPT codes for payment under the OPPS.

For CY 2008, CMS has created two parallel HCPCS codes to allow for appropriate Medicare reporting and payment for alcohol and substance abuse assessment and intervention services that are not provided as screening services, but that are performed in the context of the diagnosis or treatment of illness or injury. These codes are G0396 (Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST) and brief intervention, 15 to 30 minutes) and G0397 (Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST) and intervention, greater than 30 minutes). Coding and payment instructions for these codes will be provided in the program instructions implementing the January 2008 OPPS update.

CPT codes 99408 and 99409 are assigned status indicator “E” for CY 2008 under the OPPS, meaning they will not be recognized for payment under the OPPS or any other Medicare payment system. HCPCS codes G0396 and G0397 are assigned status indicator “S.” They are assigned with other health and behavioral assessment and intervention services to APC 0432 (Health and Behavioral Services).

## **XVI. Update of the Revised Ambulatory Surgical Center Payment System (page 66827)**

### ***XVI.D.2. Treatment of New Mid-Year Category III CPT Codes (page 66834)***

Beginning in CY 2008, CMS will include in the July quarterly update to the Ambulatory Surgical Center (ASC) payment system, the ASC payment indicators for new category III CPT codes that the AMA releases in January and that CMS determines are appropriate ASC covered surgical procedures or covered ancillary services for implementation, as payable in ASCs beginning in July of the same year. CMS will also implement annually for payment in the January update of the ASC payment system any of the category III CPT codes that the AMA released the previous July, along the new category I CPT codes that are determined to be appropriate for ASC payment. Interim ASC payment indicators will be assigned to those new mid-year category III CPT codes that are released in January for implementation in July of a given calendar year, and the interim ASC indicators will be open to comment in the OPPS/ASC proposed rule for the following calendar year and their status will be made final in the update year’s final rule.

Of the category III CPT codes the AMA released January 1, 2007, CMS has determined that only code 0182T, High dose rate electronic brachytherapy, per fraction, is appropriate for payment in ASCs as a covered ancillary radiology service. This code has been assigned to the list of covered ancillary services with payment indicator “Z2” for payment in ASCs beginning January 1, 2008.

***XVI.D.3. Treatment of Level II HCPCS Codes Released on a Quarterly Basis*** (page 66835)

The coding and payment for the services in ASCs will be updated at the same time the OPPS is updated. Newly created Level II HCPCS codes will be recognized for payment under the revised ASC payment system on a quarterly basis and new category III CPT codes will be recognized for payment on a semiannual basis, in order to parallel the policies under the Medicare Physician Fee Schedule and the OPPS. The lists of covered surgical procedures and ancillary services that qualify for separate payment in ASCs in CY 2008 have been updated by adding eight new CY 2007 Level II HCPCS codes that were implemented in the OPPS in July 2007.

***XVI.E.1. Identification of Covered Surgical Procedures*** (page 66836)

The following three procedures have been added to the ASC list of covered surgical procedures eligible for Medicare ASC payment in CY 2008: CPT codes 25931 (Amputation, forearm, through radius and ulna; re-amputation); 50580 (Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or uteropyelography, exclusive of radiologic service; with removal of foreign body or calculus); and 58805 (Drainage of ovarian cyst(s), unilateral or bilateral (separate procedure); abdominal approach).

CMS evaluated a number of procedures that individuals and organizations had requested be added or removed from the CY 2008 proposed list of ASC covered surgical procedures. Of these procedures that were requested not be excluded from this list, table 50 in the final rule (page 66837) lists those that CMS determined are appropriate for payment in an ASC along with their final CY 2008 payment indicators. Table 51 (page 66838) lists the procedures that were recommended by commenters for removal from the list. CMS has decided to retain all of the procedures in Table 51 on the final CY 2008 list of ASC covered procedures except CPT code 35474 (Transluminal balloon angioplasty, percutaneous; femoral-popliteal). The full CY 2008 list of ASC covered surgical procedures is included in Addendum AA of the final rule (page 66945).

**XVII. Reporting Quality Data for Annual Payment Rate Updates** (page 66860)

***XVII.B. Hospital Outpatient Measures*** (page 66861)

For hospitals to receive the full OPPS payment update for services furnished in CY 2009, hospital outpatient settings are required to submit data on the following seven quality measures, effective with hospital outpatient services furnished on or after January 1, 2008:

- ED-AMI-1-Aspirin at Arrival
- ED-AMI-2-Median Time to Fibrinolysis
- ED-AMI-3-Fibrinolytic Therapy Received Within 30 Minutes of Arrival

- ED-AMI-4-Median Time to Electrocardiogram (ECG)
- ED-AMI-5-Median Time to Transfer for Primary PCI
- PQRI #20 – Perioperative Care: Timing of Prophylactic Antibiotic
- PQRI #21 – Perioperative Care: Selection of Prophylactic Antibiotic

***XVII.E. Requirements for HOP QDRP for CY 2009 and Subsequent Calendar Years***  
(page 66869)

In order to participate in the Hospital Outpatient Quality Data Reporting Program (HOP QDRP), hospitals must meet certain administrative and data collection and submission requirements. CMS is not implementing a data validation requirement for purposes of the CY 2009 payment update. They intend to use validation for purposes of the CY 2010 HOP QDRP, beginning with July-September 2008 services and for subsequent services.

Hospitals not participating in the program or that withdraw from the program will not receive the full OPDS payment rate update. Those hospitals would receive a reduction of 2.0 percentage points in their updates for the affected payment year. Hospitals are required to meet the following administrative, data collection, and submission requirements under the HOP QDRP for payment determinations affecting the CY 2009 payment update:

1. Administrative requirements
  - a. Identify a QualityNet Exchange administrator who follows the registration process and submits the information through the CMS-designated contractor.
  - b. Register with the QualityNet Exchange, regardless of the method used for data submission.
  - c. Complete the Notice of Participation form and send it to a CMS-designated contractor by January 31, 2008.
2. Data Collection and Submission Requirements
  - a. Collect data required for the finalized set of measures.
  - b. Submit the data according to a data submission schedule that will be available on the QualityNet Exchange web site. Rather than requiring initial submission for services furnished on or after January 1, 2008, CMS is requiring initial submission for services furnished on or after April 1, 2008. The data submission deadline for April to June 2008 discharges is November 1, 2008, four months from the last day of the calendar quarter. Hospitals should submit data under the HOP QDRP on outpatient episodes of care to which the required measures will apply. For the purposes of the HOP QDRP, an outpatient episode of care is defined as care provided to a patient who has not been admitted as an inpatient but who is registered on the hospital's medical records as an outpatient and receives services (rather than supplies alone) directly from the hospital.
  - c. Submit complete and accurate data.
  - d. Submit the aggregate numbers of outpatient episodes of care which were eligible for submission under the HOP QDRP.

***XVII.F. Publication of HOP QDRP Data Collected*** (page 66874)

The Secretary is required to establish procedures to make data collected under the HOP QDRP available to the public and to report the quality measures on the CMS web site. CMS intends to make this information public in CY 2009 by posting it on the CMS web site. Information from non-validated data, including the initial reporting period (April-June 2008) will not be posted. Participating hospitals will be granted the opportunity to preview the information prior to its public posting.

***XVII.H. HOP QDRP Reconsiderations*** (page 66874)

A reconsideration process modeled after that for reporting inpatient quality measures will be included in the HOP QDRP for CY 2009 and subsequent calendar years.

***XVII.I. Reporting of ASC Quality Data*** (page 66875)

CMS has decided to delay implementation of ASC quality measure reporting. They believe the transition to the revised ASC payment system in CY 2008 poses such a significant challenge to ASCs that it would be most appropriate to allow some experience with the revised payment system before introducing other new requirements. Implementation of quality reporting at this time would require systems changes and other accommodations by ASCs, facilities which do not have prior experience with quality reporting as hospitals already have for inpatient quality measures, at a time when they are implementing a significantly revised payment system.

***XVII.J. FY 2009 IPPS Quality Measures Under the RHQDAPU Program*** (page 66875)

As stated in the FY 2008 hospital inpatient prospective payment system (IPPS) proposed rule, CMS proposed to add 1 outcome measure and 4 process measures to the existing 27 measure set to establish a new set of 32 quality measures to be used under the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program for the FY 2009 IPPS annual payment determination. At the time the FY 2008 IPPS final rule was published, only one of the proposed additional measures had been endorsed by the National Quality Forum (NQF). Therefore, only that measure was finalized as part of the FY 2009 IPPS measure set. Since that time, the NQF has endorsed the following additional process measures that had been proposed for inclusion in the FY 2009 RHQDAPU measure set:

- SCIP Infection 4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose
- SCIP Infection 6: Surgery Patients with Appropriate Hair Removal

Because these measures have now been endorsed by the NQF, CMS has finalized them for the FY 2009 measure set under the RHQDAPU program, bringing the total number of measures in this measure set to 30. Hospitals must start submitting data for SCIP Infection 4 and SCIP Infection 6 starting with first quarter calendar year 2008 discharges and subsequent quarters until further notice, and hospitals must submit their aggregate population and sample size counts for Medicare and non-Medicare patients.

## **XVIII. Changes Affecting Critical Access Hospitals (CAHs) and Hospital Conditions of Participation (CoPs)** (page 66877)

### ***XVIII.B. Revisions to Hospital CoPs*** (page 66882)

Changes to the requirements in the Medicare Conditions of Participation (CoPs) have been made in order to address CMS' concerns that they didn't adequately address the patient who is admitted for outpatient or same-day surgery or a procedure requiring anesthesia services. The sections on Medical Staff Bylaws and Content of Record both contain requirements for a medical history and physical examination, and an update of the medical history and physical examination documenting any changes in a patient's condition if the medical history and physical examination was completed within 30 days before admission, to be completed and documented within 24 hours after admission. Under the Surgical Services CoP, there is a provision that requires a complete history and physical workup to be in the chart of every patient prior to surgery. However, there was no requirement for an updated examination of the patient, including any changes to the patient's condition, to be completed and documented after admission or registration, and prior to any surgery or procedure being performed. Therefore, revisions have been made that require an updated examination, including any changes in a patient's condition, to be completed and documented for each patient after admission or registration and prior to surgery or to a procedure requiring anesthesia services.

The requirement regarding a preanesthesia evaluation has been revised to include the language "or a procedure requiring anesthesia services." This revision was made in order to include the range of procedures that require anesthesia services but that are not necessarily surgical in nature. The postanesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia no later than 48 hours after surgery or a procedure requiring anesthesia services, and the postanesthesia evaluation for anesthesia recovery must be completed in accordance with State law and with hospital policies and procedures that have been approved by the medical staff and that reflect current standards of anesthesia care.

## **XIX. Changes to the FY 2008 Hospital Inpatient Prospective Payment System (IPPS) Payment Rates** (page 66886)

### ***XIX.B.1. MS-DRG Documentation and Coding Adjustment*** (page 66886)

The new MS-DRG patient classification system was adopted for the IPPS, effective October 1, 2007. By increasing the number of DRGs and more fully taking into account severity of illness in Medicare payment rates, the MS-DRGs encourage hospitals to improve their documentation and coding of patient diagnoses. Because of the incentives that the MS-DRGs provide for improved documentation and coding of patient diagnoses, CMS indicated in the FY 2008 IPPS final rule that they believe the adoption of the MS-

DRGs would lead to increases in aggregate payments due to improved documentation and coding without a corresponding increase in actual patient severity of illness. To maintain budget neutrality, using the Secretary's authority to adjust the standardized amount to eliminate the effect of changes in coding or classification that do not reflect real change in case-mix, CMS established a documentation and coding adjustment of -1.2 percent for FY 2008.

Section 7 of Public Law 110-90 requires the Secretary to apply a prospective documentation and coding adjustment for discharges during FY 2008 of -0.6 percent rather than the -1.2 percent adjustment specified in the FY 2008 final rule. To comply with the provision of this law, CMS changed the IPPS documentation and coding adjustment for FY 2008 to -0.6 percent and recalculated the operating standardized amounts, capital standard Federal payment rates, the outlier threshold, the offset factors that are applied to the standardized amounts to account for projected outlier payments, and the thresholds that are used to evaluate applications for new technology add-on payments for FY 2008. All of these revised rates, factors, and thresholds are effective October 1, 2007. The revised standardized amounts are shown in Tables 1A, 1B, 1C, and 1D on page 66888 of the OPSS final rule. As expected, the standardized amounts have increased by about 0.6 percent as a result of changes in the documentation and coding adjustment required under section 7 of Public Law 110-90. The revised thresholds being used to evaluate applications for new technology add-on payments for FY 2008 under the IPPS are shown in Table 10 on pages 66888-66892 of the OPSS final rule.