The Hospital Outpatient Prospective Payment System (HOPPS) proposed rule was posted to the Centers for Medicare and Medicaid Services (CMS) website on July 3rd. There is a 60-day comment period. **Comments must be submitted to CMS by September 2, 2008.** The final rule will be published by November 1st, with an effective date of January 1, 2009.

The proposed rule includes a 3.2% increase to Medicare payment rates for most services that would be paid under the HOPPS to more than 4,000 hospitals and community mental health centers in 2009. CMS projects that hospitals would receive $28.7 billion in 2009 for outpatient services furnished to Medicare beneficiaries.

In the past, the increase in Medicare’s payment for outpatient services has not been specifically tied to the quality of health care. The law now requires that the annual HOPPS payment inflation update be reduced by 2.0 percentage points for hospitals that do not meet quality reporting requirements. In order to receive the full HOPPS payment update for services furnished in 2009, hospitals must report data in 2008 on seven (7) quality measures of emergency department and perioperative surgical care.

**SUMMARY OF 2009 PROPOSED RADIATION ONCOLOGY HOPPS PAYMENTS**

<table>
<thead>
<tr>
<th>APC</th>
<th>Description</th>
<th>CPT Codes</th>
<th>2008 Payment</th>
<th>2009 Proposed Payment</th>
<th>Payment Change 2008 to 2009</th>
<th>Percentage Change 2008 to 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>N/A</td>
<td>77417</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>0%</td>
</tr>
<tr>
<td>N</td>
<td>N/A</td>
<td>77421</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>0%</td>
</tr>
<tr>
<td>65</td>
<td>Level I SRS</td>
<td>G0251</td>
<td>$1,056.75</td>
<td>$995.33 ($61.42)</td>
<td>-5.8%</td>
<td></td>
</tr>
<tr>
<td>66</td>
<td>Level II SRS</td>
<td>G0340</td>
<td>$2,870.64</td>
<td>$2,654.40 ($216.24)</td>
<td>-7.5%</td>
<td></td>
</tr>
<tr>
<td>67</td>
<td>Level III SRS</td>
<td>G0173, G0339</td>
<td>$3,929.70</td>
<td>$3,664.34 ($265.36)</td>
<td>-6.8%</td>
<td></td>
</tr>
<tr>
<td>127</td>
<td>Level IV SRS</td>
<td>77371</td>
<td>$8,055.08</td>
<td>$7,607.56 ($447.52)</td>
<td>-5.6%</td>
<td></td>
</tr>
<tr>
<td>299</td>
<td>Hyperthermia &amp; Radiation Treatment</td>
<td>77470, 77600-77620</td>
<td>$369.40</td>
<td>$382.47</td>
<td>$13.07</td>
<td>3.5%</td>
</tr>
<tr>
<td>300</td>
<td>Level I Radiation Therapy</td>
<td>77401-77404, 77407-77409, 77789</td>
<td>$90.63</td>
<td>$91.71</td>
<td>$1.08</td>
<td>1.2%</td>
</tr>
<tr>
<td>301</td>
<td>Level II Radiation Therapy</td>
<td>77406, 77411-77416, 77422,77423, 77750</td>
<td>$141.19</td>
<td>$146.60</td>
<td>$5.41</td>
<td>3.8%</td>
</tr>
<tr>
<td>303</td>
<td>Treatment Device Construction</td>
<td>77332-77334</td>
<td>$183.94</td>
<td>$192.63</td>
<td>$8.69</td>
<td>4.7%</td>
</tr>
</tbody>
</table>
### APC Description CPT Codes 2008 Proposed Payment Payment Change 2008 to 2009 Percentage Change 2008 to 2009

<table>
<thead>
<tr>
<th>APC</th>
<th>Description</th>
<th>CPT Codes</th>
<th>2008 Payment</th>
<th>2009 Proposed Payment</th>
<th>Change 2008 to 2009</th>
<th>Percentage Change 2008 to 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>304</td>
<td>Level I Therapeutic Radiation Treatment Prep</td>
<td>77280, 77299, 77300, 77305, 77326, 77331, 77336, 77370, 77399</td>
<td>$99.21</td>
<td>$102.59</td>
<td>$3.38</td>
<td>3.4%</td>
</tr>
<tr>
<td>305</td>
<td>Level II Therapeutic Radiation Treatment Prep</td>
<td>77285, 77290, 77310, 77315, 77321, 77327, 77328</td>
<td>$250.16</td>
<td>$261.89</td>
<td>$11.73</td>
<td>4.7%</td>
</tr>
<tr>
<td>310</td>
<td>Level III Therapeutic Radiation Treatment Prep</td>
<td>55876, 77295, 77301, C9728</td>
<td>$863.82</td>
<td>$900.50</td>
<td>$36.68</td>
<td>4.2%</td>
</tr>
<tr>
<td>312</td>
<td>Radioelement Applications</td>
<td>77761, 77762, 77763, 77776, 77777, 77799</td>
<td>$542.29</td>
<td>$522.14</td>
<td>($20.15)</td>
<td>-3.7%</td>
</tr>
<tr>
<td>313</td>
<td>Brachytherapy</td>
<td>77781, 77782, 77783, 77784</td>
<td>$743.81</td>
<td>$754.18</td>
<td>$10.37</td>
<td>1.4%</td>
</tr>
<tr>
<td>412</td>
<td>IMRT Treatment Delivery</td>
<td>77418, 0073T</td>
<td>$347.65</td>
<td>$363.05</td>
<td>$15.40</td>
<td>4.4%</td>
</tr>
<tr>
<td>651</td>
<td>Complex Interstitial Radiation Source Application</td>
<td>77778</td>
<td>$1,154.31</td>
<td>$1,194.63</td>
<td>$40.32</td>
<td>3.5%</td>
</tr>
<tr>
<td>664</td>
<td>Level I Proton Beam Therapy</td>
<td>77520, 77522</td>
<td>$816.59</td>
<td>$924.55</td>
<td>$107.96</td>
<td>13.2%</td>
</tr>
<tr>
<td>667</td>
<td>Level II Proton Beam Therapy</td>
<td>77523, 77525</td>
<td>$977.09</td>
<td>$1,104.88</td>
<td>$127.79</td>
<td>13.1%</td>
</tr>
</tbody>
</table>

APC reassignment for 2009 are highlighted in **bold**

### IMAGE GUIDED RADIATION THERAPY

CMS continues to package image guidance procedures in 2009 and assign a status indicator of “N” (items and services packaged into APC rates). This policy effects CPT 76950 Ultrasonic guidance for placement of radiation fields, 76965 Ultrasonic guidance for interstitial radioelement application, 77011 CT guidance for stereotactic localization, 77014 CT guidance for placement of radiation fields, and CPT 77421 Stereoscopic x-ray guidance.

### STEREOTACTIC RADIOSURGERY (APCs 65, 66, 67 & 127)

For 2009, CMS proposes to continue the use of the four (4) G-codes for reporting LINAC-based stereotactic radiosurgery (SRS) treatment delivery and CPT 77371 for Cobalt-60 based SRS treatment delivery. The proposed payments for all SRS procedures are slated for reductions ranging from –5.6% to –7.5% in 2009 (see table above). There is no discussion in the 2009 proposed rule regarding SRS procedures.
PROSTATE NEEDLE PLACEMENT (APC 163)

CMS will maintain CPT 55875 Transperineal placement of needles into prostate in APC 163 Level IV Genitourinary Procedures with a 2009 proposed payment of $2,392.38, a 4.1% increase in 2008 payment. Reimbursement for APC 163 will only occur when CPT 55875 is not billed on the same date of service as CPT 77778.

HYPERTHERMIC THERAPIES (APC 299)

CMS maintains hyperthermic therapies (CPT 77600, 77605, 77610, 77615 & 77620) in APC 299 Hyperthermia and Radiation Treatment Procedures. The 2009 proposed payment rate for APC 299 is $382.47, a 3.5% increase in 2008 payment. This APC includes all external, interstitial and intracavitary hyperthermia procedure codes.

PLACEMENT OF INTERSTITIAL DEVICES (APC 310)

CMS proposes to reassign C9728 from APC 156 Level III Urinary and Anal Procedures to APC 310 Level III Therapeutic Radiation Treatment Preparation with a 2009 proposed payment rate of $900.50, a 364% increase over the 2008 payment of $194.07.

C9728 Placement of interstitial device(s) for radiation therapy/surgery guidance (eg, fiducial markers, dosimeter), other than prostate (any approach) single or multiple

CMS proposes to reassign CPT 55876 from APC 156 Level III Urinary and Anal Procedures to APC 310 Level III Therapeutic Radiation Treatment Preparation with a 2009 proposed payment rate of $900.50, a 364% increase over the 2008 payment of $194.07.

55876 Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach) single or multiple

There is no discussion in the 2009 proposed rule regarding reassignment of interstitial devices to APC 310.

INTENSITY MODULATED RADIATION THERAPY (APCs 310 & 412)

CMS will maintain CPT 77301 IMRT planning in APC 310 Level III Therapeutic Radiation Treatment Preparation with a 2009 proposed payment of $900.50, a 4.2% increase in 2008 payment.

CMS will maintain CPT codes 77418 MLC-based IMRT delivery and 0073T Compensator-based IMRT delivery in APC 412 IMRT Treatment Delivery with a 2009 proposed payment of $363.05, a 4.4% increase in 2008 payment.
LOW DOSE RATE BRACHYTHERAPY/RADIOELEMENT APPLICATION (APC 312)

The 2009 proposed payment rate for APC 312 Radioelement Applications (CPT 77761, 77762, 77763, 77776, 77777 & 77799) is $522.14, a 3.7% decrease in current payment of $542.29. This APC includes all Low Dose Rate (LDR) brachytherapy procedures (with the exception of CPT 77778) and the unlisted brachytherapy procedure code 77799.

HIGH DOSE RATE BRACHYTHERAPY (APC 313)

The 2009 proposed APC payment rate for APC 313 Brachytherapy (CPT 77781-77784) is $754.18, a 1.4% increase in 2008 payment. This APC includes all High Dose Rate (HDR) brachytherapy procedures.

BREAST BRACHYTHERAPY CATHETER PLACEMENT (APC 648)

For 2009, CMS maintains the breast brachytherapy catheter placement codes (CPT 19296, 19297 & 19298) in clinical APC 648 Level IV Breast Surgery. The 2009 proposed payment is $3,803.18, a 5.5% increase in the 2008 payment of $3,603.64.

COMPLEX INTERSTITIAL RADIATION SOURCE APPLICATION (APC 651)

The 2009 proposed payment rate for CPT 77778 in APC 651 Complex Interstitial Radiation Source Application is $1,194.63, a 3.5% increase in 2008 payment. Reimbursement for APC 651 will only occur when CPT 77778 is not billed on the same date of service as CPT 55875.

PROTON BEAM THERAPY (APCs 664 & 667)

CMS maintains the simple proton beam therapy codes (CPT 77520 & 77522) in APC 664 Level I Proton Beam Therapy Codes. The 2009 proposed payment of $924.55 increases 13.2% from 2008 payment of $816.59.

Further, CMS will maintain the intermediate (CPT 77523) and complex (CPT 77525) proton beam therapy codes in APC 667. The 2009 proposed payment of $1,104.88 increases 13.1% from 2008 payment of $977.09.

HDR ELECTRONIC BRACHYTHERAPY (NEW TECHNOLOGY APC 1519)

For 2009, CMS maintains Category III CPT 0182T for High Dose Rate (HDR) Electronic Brachytherapy in New Technology APC 1519 with a 2009 proposed payment rate of $1,750.00 per fraction.

LOW DOSE RATE (LDR) PROSTATE COMPOSITE APC (APC 8001)

See “Composite APCs” below.
NEW CATEGORY III CODES

CMS proposes to assign new Category III code 0190T to APC 237 Level II Posterior Segment Eye Procedures effective January 1, 2009. APC 237 has a 2009 proposed payment of $1,449.34. This code is subject to comment.

0190T Placement of intraocular radiation source applicator

New Category III code 0197T was released on July 1, 2008 and will become effective on January 1, 2009. For the proposed rule, CMS did not assign this code to a clinical APC. CMS will recognize 0197T in the 2009 final rule and APC assignment will be subject to public comment.

0197T Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy (eg, 3D positional tracking, gating, 3D surface tracking), each fraction of treatment.

BRACHYTHERAPY SOURCES

NOTE: The Medicare Improvements for Patients and Providers Act of 2008 was enacted into law on July 15, 2008, which extends the current HOPPS payment methodology of hospital charges adjusted to cost for brachytherapy sources through December 31, 2009.

A. Continued Separate Payment for Brachytherapy Sources

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 requires CMS to continue separate payment for brachytherapy sources in 2009 and subsequent years, in addition to the procedure APCs.

B. Proposed Payments for Brachytherapy Sources

For 2009, CMS proposes to pay separately for each of the brachytherapy sources on a prospective basis, with payment rates to be determined using the 2007 claims-based median cost per source for each brachytherapy device.

CMS notes that the first partial year of claims data for separately coded stranded and non-stranded Iodine, Palladium and Cesium sources is available in the 2007 claims data that is used for 2009 ratesetting for brachytherapy sources. CMS states that they have sufficiently robust 2007 claims data for all payable brachytherapy sources, including stranded and non-stranded sources (see Table 29 on pages 341-342).

Further, CMS proposes to pay for the stranded and non-stranded “not otherwise classified” codes (C2698 & C2699) based on the rate equal to the lowest stranded or non-stranded prospective payment rate for such sources, respectively, on a per source basis (see table below).
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A9527</td>
<td>Iodine I-125, sodium iodide solution, therapeutic, per millicurie</td>
<td>2632</td>
<td>U</td>
<td>$36</td>
<td>$36.05</td>
</tr>
<tr>
<td>C1716</td>
<td>Brachytherapy source, non-stranded, Gold-198, per source</td>
<td>1716</td>
<td>U</td>
<td>$34</td>
<td>$33.90</td>
</tr>
<tr>
<td>C1717</td>
<td>Brachytherapy source, non-stranded, High Dose Rate Iridium-192, per source</td>
<td>1717</td>
<td>U</td>
<td>$212</td>
<td>$211.88</td>
</tr>
<tr>
<td>C1719</td>
<td>Brachytherapy source, non-stranded, Non-High Dose Rate Iridium-192, per source</td>
<td>1719</td>
<td>U</td>
<td>$65</td>
<td>$64.71</td>
</tr>
<tr>
<td>C2616</td>
<td>Brachytherapy source, non-stranded, Yttrium-90, per source</td>
<td>2616</td>
<td>U</td>
<td>$13,426</td>
<td>$13,449.68</td>
</tr>
<tr>
<td>C2634</td>
<td>Brachytherapy source, non-stranded, High Activity, Iodine-125, greater than 1.01 mCi (NIST), per source</td>
<td>2634</td>
<td>U</td>
<td>$43</td>
<td>$42.81</td>
</tr>
<tr>
<td>C2635</td>
<td>Brachytherapy source, non-stranded, High Activity, Palladium-103, greater than 2.2 mCi (NIST), per source</td>
<td>2635</td>
<td>U</td>
<td>$27</td>
<td>$26.94</td>
</tr>
<tr>
<td>C2636</td>
<td>Brachytherapy linear source, non-stranded, Palladium-103, per 1MM</td>
<td>2636</td>
<td>U</td>
<td>$60</td>
<td>$60.44</td>
</tr>
<tr>
<td>C2637</td>
<td>Brachytherapy source, non-stranded, Ytterbium-169, per source</td>
<td>2637</td>
<td>B</td>
<td>$0</td>
<td>$0.00</td>
</tr>
<tr>
<td>C2638</td>
<td>Brachytherapy source, stranded, Iodine-125, per source</td>
<td>2638</td>
<td>U</td>
<td>$40</td>
<td>$40.36</td>
</tr>
<tr>
<td>C2639</td>
<td>Brachytherapy source, non-stranded, Iodine-125, per source</td>
<td>2639</td>
<td>U</td>
<td>$36</td>
<td>$36.47</td>
</tr>
<tr>
<td>C2640</td>
<td>Brachytherapy source, stranded, Palladium-103, per source</td>
<td>2640</td>
<td>U</td>
<td>$66</td>
<td>$66.54</td>
</tr>
<tr>
<td>C2641</td>
<td>Brachytherapy source, non-stranded, Palladium-103, per source</td>
<td>2641</td>
<td>U</td>
<td>$63</td>
<td>$63.44</td>
</tr>
<tr>
<td>C2642</td>
<td>Brachytherapy source, stranded, Cesium-131, per source</td>
<td>2642</td>
<td>U</td>
<td>$100</td>
<td>$99.70</td>
</tr>
<tr>
<td>C2643</td>
<td>Brachytherapy source, non-stranded, Cesium-131, per source</td>
<td>2643</td>
<td>U</td>
<td>$59</td>
<td>$59.45</td>
</tr>
<tr>
<td>C2698</td>
<td>Brachytherapy source, stranded, not otherwise specified, per source</td>
<td>2698</td>
<td>U</td>
<td>$40</td>
<td>$40.36</td>
</tr>
<tr>
<td>C2699</td>
<td>Brachytherapy source, non-stranded, not otherwise specified, per source</td>
<td>2699</td>
<td>U</td>
<td>$27</td>
<td>$26.94</td>
</tr>
</tbody>
</table>
CMS invites hospitals and other parties to submit recommendations regarding new HCPCS codes to describe new brachytherapy sources consisting of a radioactive isotope, including a detailed rationale to support recommended new sources.

C. New Brachytherapy Source HCPCS Codes & Descriptors

CMS proposes to continue their policy regarding payment for new brachytherapy sources for which they have no claims data. CMS would assign future new HCPCS codes for new brachytherapy sources to their own APCs, with prospective payment rates set based on CMS consideration of external data and other relevant information regarding the expected costs of the sources to hospitals.

D. Proposed Change to Brachytherapy Source Status Indicator

For 2009, CMS proposes to establish a new status indicator “U” for brachytherapy sources. CMS states that the new status indicator for brachytherapy sources will facilitate implementation of the reduced market basket conversion factor that would apply to payments to hospitals that are required to report quality data but fail to meet the established quality reporting standards. Brachytherapy sources would be subject to the reduced conversion factor.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Item/Code/Service</th>
<th>HOPPS Payment Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>U</td>
<td>Brachytherapy Sources</td>
<td>Paid under OPPS; Separate APC payment</td>
</tr>
</tbody>
</table>

**COMPOSITE APCS**

In 2008, CMS developed composite APCs to provide a single payment for groups of services that are typically performed together during a single clinical encounter. CMS states that they continue to consider the development and implementation of larger payment bundles, such as composite APCs, a long-term policy objective for the HOPPS.

In 2009, CMS will continue the composite APC policies for extended assessment and management, low dose rate (LDR) prostate brachytherapy, cardiac electrophysiologic evaluation and ablation, and mental health services. **CMS is proposing to expand the composite APC model to one new clinical area in 2009, multiple imaging services.**

A. Low Dose Rate Prostate Composite APC (APC 8001):

Beginning in 2008, CMS provides a single payment for LDR prostate brachytherapy when the composite service, billed as CPT codes 55875 and 77778, is furnished in a single hospital encounter. CMS bases the payment for composite APC 8001 on the median cost derived from claims for the same date of service that contain both CPT codes 55875 and 77778 and that do not contain other separately paid codes that are not on the bypass list.

For 2009, CMS proposes to continue paying for LDR prostate brachytherapy services using the composite APC methodology implemented in 2008. The 2009 proposed payment for APC 8001 is $3,515.60, a 2.4% increase in 2008 payment. **CMS proposes a new status indicator “Q3” to denote CPT codes 55875 and 77778 that may be paid through a composite APC in 2009 (rather than status indicator “Q” that is being used in 2008).**
Using partial year 2007 claims data available for the 2009 proposed rule, CMS was able to use 6,897 claims that contained both CPT code 77778 and 55875 to calculate the median cost of composite APC 8001. The proposed median cost for composite APC 8001 for 2009 is approximately $3,509. This is an increase compared to the 2008 HOPPS final rule in which CMS calculated the median cost of composite APC 8001 at $3,391.

The 2009 proposed composite APC median is slightly less than the $3,581, the sum of the proposed median costs for APC 0163 (CPT 55875) and 0651 (CPT 77778).

\[
\begin{align*}
\text{APC 0163 proposed median cost} & = $2,388 \\
\text{APC 0651 proposed median cost} & = $1,193 \\
\end{align*}
\]

\[
\text{Total proposed median cost} = $3,581 \text{ vs. } 2009 \text{ proposed median cost of APC 8001} = $3,391
\]

CMS continues to pay for CPT 55875 through APC 163 and to pay for CPT 77778 through APC 651 when the services are individually furnished other than on the same date of services in the same facility. These codes are now assigned status indicator “Q3.”

B. Multiple Imaging Composite APCs (APC 8004, 8005, 8006, 8007 and 8008):

Under current HOPPS policy, hospitals receive a full APC payment for each imaging service, regardless of how many procedures are performed during a single session using the same imaging modality or whether the procedures are performed on contiguous body areas.

In preparation of the 2009 proposed rule, CMS considered how to improve the accuracy of the HOPPS payment for multiple imaging services and incorporate the lower marginal cost for conducting a second and subsequent imaging procedure in the same imaging session. CMS reexamined the eleven (11) imaging families of HCPCS codes for contiguous body areas involving a single imaging modality that was proposed under HOPPS for CY 2006 and are currently used under the Medicare Physician Fee Schedule (MPFS) for the multiple imaging procedure payment reduction policy.

CMS collapsed the 11 MPFS imaging families into three (3) HOPPS imaging families according to modality—ultrasound, CT and CTA, MRI and MRA. CMS then removed any HCPCS codes in the HOPPS imaging families that overlap with codes on the “bypass” list to avoid splitting claims (see Table 7 Imaging HCPCS removed from the bypass list for purposes of calculating proposed composite median costs on pages 139-140). Next CMS created line-items for HCPCS codes in the HOPPS imaging families remaining on multiple procedure claims, with one unit of the imaging HCPCS code and no other imaging services in the families, into “pseudo” single bills for use in calculating the median costs for sole imaging services. The HOPPS families for the three modalities were expanded into five (5) composite APCS to accommodate imaging services provided with and without contrast.
CMS determined that a proposal to revise the current methodology for paying for multiple imaging procedures is warranted because the current HOPPS policy of providing a full APC payment for each imaging service on a claim neither reflects nor promotes efficiency.

For 2009, CMS proposes to utilize the 3 HOPPS imaging families, incorporating statutory requirements to differentiate HOPPS payment for imaging services provided with contract and without contrast, to create 5 multiple imaging composite APCs. The proposed APCs are: APC 8004 Ultrasound Composite; APC 8005 CT and CTA without Contrast Composite; APC 8006 CT and CTA with Contrast Composite; APC 8007 MRI and MRA without Contrast Composite; and APC 8008 8007 MRI and MRA with Contrast Composite. (See Table 8 Proposed HOPPS Imaging Families and Multiple Imaging Procedure Composite APCs on pages 144-148). HCPCS codes in Table 8 are assigned status indicator “Q3” effective January 1, 2009. The proposed composite APCS have status indicator “S,” signifying that payment for the APC would not be reduced when appearing on the same claim as other significant procedures.

<table>
<thead>
<tr>
<th>2009 Proposed Composite APC</th>
<th>Status Indicator</th>
<th>2009 Proposed Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>8004 Ultrasound Composite</td>
<td>S</td>
<td>$194.48</td>
</tr>
<tr>
<td>8005 CT and CTA without Contrast Composite</td>
<td>S</td>
<td>$423.72</td>
</tr>
<tr>
<td>8006 CT and CTA with Contrast Composite</td>
<td>S</td>
<td>$640.22</td>
</tr>
<tr>
<td>8007 MRI and MRA without Contrast Composite</td>
<td>S</td>
<td>$725.94</td>
</tr>
<tr>
<td>8008 MRI and MRA with Contrast Composite</td>
<td>S</td>
<td>$1,004.49</td>
</tr>
</tbody>
</table>

To implement the proposed policy, CMS would provide one composite APC payment each time a hospital bills more than one procedure described by the HCPCS codes in one HOPPS imaging family (Table 8) on a single date of service. If the hospital performs a procedure without contrast during the same session as at least one other procedure with contrast using the same imaging modality, then the hospital would receive payment for the “with contrast” composite APC. A single imaging procedure, or imaging procedures reported with HCPCS codes assigned to different HOPPS imaging families, would be paid according to the standard HOPPS methodology.

**PACKAGED SERVICES**

Over the past several years of the HOPPS, greater unpackaging of payment has occurred simultaneously with continued growth in HOPPS expenditures as a result of increasing volumes of services. In an attempt to address this increase in volume of services, in the 2008 HOPPS final rule CMS adopted packaging of payment for items and services in seven categories (listed below) into the payment for the primary diagnostic or therapeutic modality to which these items and services are typically ancillary and supportive. The seven categories are:

- Guidance services
- Image processing services
- Intraoperative services
- Imaging supervision and interpretation services
- Diagnostic radiopharmaceuticals
- Contrast media
- Observation services

For 2009, CMS proposes to further refine their identification of the different types of conditionally packaged HCPCS codes, which were previously assigned status indicator “Q.” CMS proposes to create and assign status indicators Q1 STVX-packaged codes; Q2 T-packaged codes; or Q3 Codes that may be paid through a composite APC.

A. Guidance Services

For 2009, CMS proposes to maintain the packaged status of radiation oncology guidance services. CMS states that while they are aware that some of the radiation oncology guidance codes describe relatively new technologies, they do not believe that beneficiary access to care would be harmed by packaging payment for these radiation oncology services. CMS states that packaging will create incentives for hospitals and their physician partners to work together to establish appropriate protocols that will eliminate unnecessary services where they exist and institutionalize approaches to providing necessary services more efficiently. CMS states that they see no basis for treating radiation oncology services differently from other guidance services that are ancillary and dependent to the procedures they facilitate.

During the March 2008 APC Advisory Panel, the Panel recommended that CMS provide additional data to support packaging radiation oncology guidance services for review by the Data Subcommittee at the next APC Panel meeting (i.e. August 27-29, 2008). CMS adopted the Panel’s recommendation and will provide data related to radiation oncology guidance services at the next APC Panel meeting.

NEW TECHNOLOGY APCS

For 2009, CMS proposes to reassign procedures from New Technology APCs to Clinical APCs:

- CMS proposes the reassignment of C9725 from New Technology APC 1507 ($550.00) to clinical APC 164 Level II Urinary and Anal Procedures ($144.92), a 74% decrease in 2008 reimbursement.
  
  C9725 Placement of endorectal intracavitary applicator for high intensity brachytherapy

- CMS proposes the reassignment of C9726 from New Technology APC 1508 ($650.00) to clinical APC 28 Level I Breast Surgery ($1,412.23), a 117% increase in 2008 reimbursement.
  
  C9726 Placement and removal (if performed) of applicator into breast for radiation therapy
TWO TIMES RULE

APCs are organized such that each group is homogenous both clinically and in terms of resource use. An APC group cannot be considered comparable with respect to the use of resources if the highest median cost for a procedure in the group is more than 2 times greater than the lowest median cost for a procedure in the same group (referred to as the 2x Rule). The statute authorizes CMS to make exceptions to the 2x Rule in unusual cases, such as low-volume services.

For 2009, CMS proposes to exempt APC 303 Treatment Device Construction from the 2x Rule. (See Table 13 on pages 220-221 for a list of proposed APC Exceptions to the 2x Rule for 2009.)

METHODOLOGY TO RECALIBRATE RELATIVE WEIGHTS

CMS is required to review and revise the relative payment weights for APCs at least annually. CMS proposes to use the same basic methodology that has been used since the inception of the HOPPS to recalibrate the APC relative payment weights for services furnished on or after January 1, 2009 and before January 1, 2010 (calendar year 2009). The APC relative weights continue to be based on median hospital costs for services in the APC groups.

A. Database Source and Methodology

CMS proposes to recalibrate the relative APC payment weights for 2009 using claims data for outpatient services furnished between January 1 and December 31, 2007.

The base APC median costs will be based on single and “pseudo” single procedure claims for services furnished in 2007 and processed before January 1, 2008.

B. Proposed Use of Single and Multiple Procedure Claims

For 2009, in general, CMS proposes to continue to use single procedure claims to set the medians on which the relative weights are based, with some exceptions. CMS notes that they continue to receive many requests to ensure that the data from claims that contain charges for multiple procedures are included in the data to calculate the 2009 relative payment weights.

For 2009, CMS proposes to continue the use of the “date of service” on the claims and a list of codes to be “bypassed” to create more “pseudo” single claims from multiple procedure claims.

CMS proposes to continue the use of the codes on the 2008 bypass list. CMS proposes to use the empirical criteria to determine additional codes to be added to the bypass list for 2009. In addition, CMS proposes to add to the bypass list codes that their clinicians believe have minimal associated packaging based on their clinical assessment of the full 2009 HOPPS proposal. For 2009, CMS proposes to bypass 452 HCPCS codes (see Table 1 on pages 49-59).
CMS uses single procedure claims to set the median costs for APCs because thus far, they are unable to ensure that packaged costs can be correctly allocated across multiple procedures performed on the same date of service. However, bypassing specified codes that do not have significant packaged costs enables use of more data from multiple procedure claims.

CMS used some or all of the data from 96% of the total claims eligible for use in the HOPPS ratesetting for the 2009 proposed rule. CMS created approximately 60 million “pseudo” single claims and 30 million “natural” single bills yielding approximately 90 million claims for 2009 HOPPS ratesetting.

C. Proposed Calculation of Cost-to-Charge Ratios (CCR)

CMS references RTI’s recently released July 2008 report “Refining Cost to Charge Ratios for Calculating APC and DRG Relative Payment Weights”. The report contained eleven (11) recommendations (2 of which were hospital inpatient specific). Of the remaining nine (9) recommendations some concentrated on short-term accounting changes to current cost report data and the others addressed short-term regression-based and other statistical adjustments. CMS is not proposing to adopt any short-term adjustments to HOPPS payment rate calculations in 2009 due to the magnitude and scope of impacts on APC relative weights that would result from adopting both accounting and statistical changes. CMS states that the numerous and substantial changes recommended by RTI have significantly complex interactions with each other. The agency believes they should proceed with caution.

RTI noted that many hospitals combine costs and charges for therapeutic radiology and nuclear medicine services under the diagnostic radiology cost center, when these are services with their own specific and distinct charges and cost centers. CMS states that they will seek to better understand the reason for this aggregation.

CMS is also considering creating standard cost centers for CT Scanning, MRI, and Cardiac Catheterization as they revise the Medicare hospital cost report form. CMS notes that standard cost centers would do more to require hospitals to break out their costs and charges for services in these clinical areas. CMS is seeking public comment on the creation of standard costs centers for CT Scanning, MRI, and Cardiac Catheterization, rather than continuing the established nonstandard cost centers.

CMS states that the accuracy of capital cost allocation under Medicare allocation methods remains an issue when discussing the accuracy of CCRs for radiology and other capital-intensive services. CMS notes that they are supportive of industry-led educational initiatives to improve the quality of reporting capital costs on the cost report.

For 2009, CMS is proposing to adopt or support several accounting recommendations that would improve the accuracy of cost report data, including educational initiatives in reporting capital costs, additional standard cost centers on the hospital cost report for “Drugs with High Overhead Costs” and “Drugs with Low Overhead Costs,” adding fixed descriptions to the cost report software, and clarifying instructions requiring hospitals to report all standard cost centers if they offer services of the appropriate type.
In addition, CMS is seeking public comment on several of RTI’s recommended accounting-based changes to the cost report (as they plan to consider the comments as they revise the Medicare hospital cost report and in decisions related to the 2010 HOPPS rulemaking). (See pages 61-74)

D. Proposed Status Indicators

CMS proposes new status indicators effective January 1, 2009: “U” for all brachytherapy sources; “Q1” assigned to all STVX-packaged codes; “Q2” assigned to T-packaged codes; and “Q3” assigned to all codes that may be paid through a composite APC based in composite-specific criteria or paid separately through single code APCs when the criteria are not met.

CMS will continue their current policy of defining a major procedure as any procedure having a status indicator of S, T, V or X; defining minor procedures as any code having a status indicator of F, G, H, K, L, R, U or N; and classifying “other” procedures as any code having a status indicator other than one classified as major or minor.

E. Proposed Calculation of HOPPS Scaled Payment Weights

CMS continues the proposal to scale all relative payment rates to the median cost of APC 0606 (Level 3 Hospital Clinic Visits).

**CONVERSION FACTOR**

**The proposed 2009 conversion factor is $65.684.** For 2009, the conversion factor update is equal to the hospital inpatient market basket, which is forecasted at 3.0%. The proposed market basket update, the required wage index budget neutrality adjustment (1.0010), and the proposed adjustment of 0.02% of projected HOPPS spending for the difference in the pass-through set aside results in a proposed full market basket conversion factor for 2009 of $65.684.

Hospitals that do not meet the reporting requirement of the Hospital Outpatient Quality Data Reporting program are subject to a 2% reduction from the market basket update to the conversion factor. **The reduced market basket conversion factor for 2009 is $64.409.**

**PASS-THROUGH PAYMENTS FOR DEVICES**

A. Pass-Through Payment for Device Codes

**CMS finalized their policy to expire device categories C1821 (interspinous process distraction device) and L8690 (auditory osseointegrated device) from pass-through device payment after December 31, 2008.**

CMS has no established device categories eligible for pass-through payment continuing into 2009.
B. Proposed Revisions for Reducing Transitional Pass-Through Payments to Offset Costs Packaged into APC Groups

CMS proposes to continue their established policies for calculating and setting APC offset amounts for each device category eligible for pass-through payment.

C. Proposed Adjustment to HOPPS Payment for Partial or Full Credit Devices

For 2009, CMS is proposing to continue the policy of reducing HOPPS payment by 100% of the device offset amount when a hospital furnishes a specified device without cost or with a full credit and by 50% of the device offset amount when the hospital received partial credit in the amount of 50% or more of the cost for the device.

CMS is also proposing to continue using the 3 criteria established in the 2007 HOPPS final rule for determining the APCs to which the policy applies. Specifically, 1. all procedures assigned to the selected APCs must require implantable devices that would be reported if device insertion procedures were performed, 2. required devices must be surgically inserted or implanted devices that remain in the patient’s body after the conclusion of the procedures (at least temporarily), and 3. device offset amount must be significant (exceeding 40% of the APC cost).

For 2009, CMS proposes to add APC 648 Level IV Breast Surgery and their associated devices that would not otherwise be on the device list for 2009 because the device offset percentages are above the 40% threshold based on the 2007 claims data.

Table 18 lists the proposed APCs to which the payment reduction policy for full credit/no cost and partial credit devices would apply in 2009 and displays the proposed payment reduction percentages for both circumstances. This policy applies to APC 648 Level IV Breast Surgery, which includes CPT codes 19296-19298 for placement of breast brachytherapy catheters. The proposed 2009 reduction for APC 648 for full credit case is 41%; and reduction for partial credit case is 21% (see page 250).

Table 19 lists the proposed devices to which the policy would apply in 2009 and includes breast brachytherapy catheter C1728 (see page 251).

D. Estimate of Transitional Pass-Through Payments for 2009

CMS proposes to set the pass-through pool at the applicable percentage cap at 2.0% of the total HOPPS projected payments for 2009. The total pass-through estimate for 2009 is $18.9 million ($10 million for devices and $8.9 million for drugs). Because CMS estimates pass-through spending will not amount to 2.0% of total projected HOPPS 2009 spending, CMS proposes to return 1.93% of the pass-through pool to adjust the conversion factor.
OTHER CMS PROPOSED PAYMENT POLICIES

A. Hold Harmless Transitional Payments

Transitional corridor payments were intended to be temporary payments for most providers but permanent payments for cancer and children’s hospitals to ease their transition from the prior reasonable cost-based system to the prospective payment system. The Deficit Reduction Act of 2005 (DRA) reinstituted the hold harmless transitional outpatient payments for covered services furnished on or after January 1, 2006 and before January 1, 2009, for rural hospitals having 100 or fewer beds that are not sole community hospitals (SCH).

Effective for services provided on or after January 1, 2009, rural hospitals having 100 or fewer beds that are not SCHs will no longer be eligible for hold harmless transitional outpatient payments.

B. Adjustment for Rural Sole Community Hospitals

For 2009, CMS proposes to continue the current policy of a budget neutral 7.1% payment increase for rural sole community hospitals, including essential access community hospitals (EACH), for all services and procedures paid under HOPPS, excluding drugs, biologicals and services paid under the pass-through payment policy.

CMS proposes to include brachytherapy sources in the group of services eligible for the 7.1% payment increase because CMS proposes to pay them at prospective rates based on their median costs as calculated from claims data.

C. Outlier Policy

Outlier payments were created to provide additional payment for high cost services not covered by the HOPPS payment rate. For 2009, CMS proposes to continue their policy of setting aside 1.0% of aggregate total payment under HOPPS for outlier payments. An amount equal to 0.07% of the outlier payments would be allocated to community mental health centers (CMHCs) for partial hospitalization program service outliers.

CMS proposes to trigger outlier payments when the cost of furnishing a service or procedure by a hospital exceeds 1.75 times the APC payment amount and exceeds the APC payment rate plus a $1,800 fixed dollar threshold. CMS will continue to pay 50% of the amount over the 1.75 times threshold.

CMS is concerned that they may systematically overestimate the HOPPS hospital outlier threshold if they did not apply a CCR inflation adjustment factor. The CCR inflation adjustment factor that will apply to the 2009 HOPPS is 0.9920.

CMS is also proposing that the hospital costs, for hospitals that fail to meet the quality reporting data requirements, be compared to the reduced payments for purposes of outlier eligibility and payment calculation.
For 2009, CMS proposes to address vulnerabilities in the HOPPS outlier payment system that lead to differences between billed charges and charges included in the overall CCR used to estimate cost by updating the regulations to codify existing outlier policies and implementing a reconciliation process (see pages 191-201).

D. Device-Dependent APCs

For 2009, CMS proposes to use its standard methodology for calculating median costs for device-dependent APCs, which utilizes claims data that generally represent the full cost of the required device. Specifically CMS will calculate the median for device-dependent APCs for 2009 using only the subset of single bills from 2007 claims data that pass the procedure to device edits; do not contain token charges for devices; and do not contain the “FB” modifier signifying that the device was furnished without cost to the provider, supplier, or practitioner, or where a full credit was received.

CMS proposes to delete APC 0625 because no other procedures would map to it once CPT 36566 is reassigned.

E. Payment Changes for Drugs, Biologicals and Radiopharmaceuticals

NOTE: The Medicare Improvements for Patients and Providers Act of 2008 was enacted into law on July 15, 2008, which extends the current HOPPS payment methodology of hospital charges adjusted to cost for therapeutic radiopharmaceuticals through December 31, 2009.

CMS proposes to pay for the combined average acquisition and pharmacy overhead cost of separately payable drugs and biologics ($60 per day threshold) at average sales price (ASP) plus 4%. In addition, CMS proposes to break the single standard cost center 5600 into two standard cost centers, Drugs with High Overhead Cost Charged to Patients and Drugs with Low Overhead Cost Charged to Patients.

CMS proposes to provide payment for separately payable therapeutic radiopharmaceuticals ($60 per day threshold) that submit ASP information through the existing ASP process at ASP plus 4% as the best proxy for therapeutic radiopharmaceutical average acquisition and handling costs. If ASP information is not available, CMS is proposing that payment would be based upon mean costs from hospital claims data (see Table 25 on page 319).

For 2009, CMS proposes to package all diagnostic radiopharmaceuticals and contrast agents regardless of their per day costs. CMS views diagnostic radiopharmaceuticals and contrast agents as ancillary and supportive of the diagnostic tests and therapeutic procedures in which they are used.

CMS proposes to pay for pass-through drugs and biologics (that are not part of the Part B Drug Competitive Acquisition Program) at ASP plus 6%. For 2009, CMS proposes to provide payment for diagnostic and therapeutic radiopharmaceuticals that are granted pass-through status based on the ASP methodology plus 6%. If ASP data is not available for a radiopharmaceutical, CMS proposes to base the pass-through payment on the products wholesale acquisition cost (WAC); or if WAC is also not available, at 95% of average wholesale price (AWP).
F. Beneficiary Copayment

By law, the national unadjusted copayment must be reduced annually. For 2009, CMS proposes to continue reducing the copayment to a maximum coinsurance amount of 40% of the APC payment rate for 2009. The minimum beneficiary copayment is 20% of the APC payment rate. CMS expects that the beneficiary share of the proposed total payments for Medicare covered outpatient services will be about 23% in 2009.

G. Inpatient Only Procedures

CMS proposes to remove eleven (11) procedures from the “inpatient only” list and assign them to clinically appropriate APCs in 2009 (see Table 35 on page 400).

H. Physician Supervision of Hospital Outpatient Services

CMS provides a restatement and clarification of the requirements for physician supervision of therapeutic hospital outpatient services (see pages 401-406). In summary, direct physician supervision is the standard set forth in the April 7, 2000 HOPPS final rule for supervision of hospital outpatient therapeutic services covered and paid by Medicare in hospitals and provider-based departments of hospitals. While CMS has emphasized and will continue to emphasize the direct supervision requirement for off-campus provider-based departments, they are reiterating their expectation of direct physician supervision of all hospital outpatient therapeutic services, regardless of their on-campus or off-campus location. Appropriate supervision is a key aspect of the delivery of safe and high quality hospital outpatient services that are paid based on the statutory authority of the HOPPS.

I. Reporting Quality Data for Annual Payment Rate Updates

The Tax Relief and Health Care Act of 2006 requires the Secretary of Health and Human Services to develop measures appropriate for the measurement of the quality of care (including medication errors) furnished by hospitals in outpatient settings.

The Medicare, Medicaid, and SCHIP Extension Act of 2007 requires that hospitals that fail to report data required for the quality measures selected by the Secretary of Health and Human Services will incur a reduction in their annual payment update factor by 2.0 percentage points effective January 1, 2009.

As required by law, CMS is proposing to reduce the proposed 2010 market basket inflation update for those hospitals that fail to successfully report required quality measures beginning in 2009 by 2.0 percentage points. The proposed reduction would not apply to payments for pass-through drugs and devices, separately payable drugs and biologicals, separately payable therapeutic radiopharmaceuticals, and services assigned to New Technology APCs. CMS is also proposing to reduce the beneficiary copayment amount for services furnished in hospitals that have not met their reporting requirements so that beneficiaries share in the reduction of payments to these hospitals.
In addition, CMS is proposing to add four (4) imaging efficiency measures that would be calculated using Medicare claims data, increasing the number of measures that must be reported from seven (7) in 2008 (5 emergency department and 2 perioperative care measures) to eleven (11) in 2009, in order for hospitals to receive the full market basket updates in 2010. CMS invites public comment on the 4 proposed imaging measures. The 4 imaging efficiency measures are:

- OP-8: MRI Lumbar Spine for Low Back Pain
- OP-9: Mammography Follow-up Rates
- OP-10: Abdomen CT- Use of Contrast Material
- OP-10a: CT Abdomen Use of Contrast Material excluding calculi of the kidneys, ureter, and/or urinary tract
- OP-10b: CT Abdomen- Use of Contrast Material for diagnosis of calculi in the kidneys, ureter, and/or urinary tract
- OP-11: Thorax CT- Use of Contrast Material

For consideration of future HOPPS updates, CMS is seeking public comment on eighteen (18) additional potential quality measures in areas including cancer care, emergency department throughput, screening for fall risk, and management of certain clinical conditions such as depression, stroke and rehabilitation, osteoporosis, asthma, and community-acquired pneumonia (see pages 487-488).

CMS is also proposing to implement a data validation approach for 2010 starting with January 2009 encounters. This proposed validation approach would randomly select 800 reporting hospitals and validate the accuracy of reported data by selecting 50 records per selected hospital on an annual basis. CMS is seeking comments on this validation methodology.

J. Healthcare-Associated Conditions

To build on other efforts across the Medicare program to strengthen the connection between the quality of care and Medicare payment, CMS is seeking public comment on options and considerations for modifying payments for treating conditions that are generally preventable if the provider follows established guidelines. CMS is already implementing a similar policy for inpatient stays under authority granted in the Deficit Reduction Act of 2005, and beginning for discharges on or after October 1, 2008, CMS will no longer pay hospitals at a higher rate for treating certain conditions that have been determined to be reasonably preventable by following evidence-based guidelines, if they are acquired during an inpatient stay.

CMS states that a key part of value-based purchasing strategy is to link Medicare payment to quality of care by providing incentives for hospitals to follow established guidelines and reduce the number of preventable conditions that occur as a result of treatment.