

**Date:** August 19, 2008

**Subject:** Proposed Changes to the Hospital Outpatient Prospective Payment System and CY 2009 Payment Rates

This document summarizes the calendar year (CY) 2008 proposed rule for Medicare hospital outpatient payment titled: *CMS-1404-P: Proposed Changes to the Hospital Outpatient Prospective Payment System and CY 2009 Payment Rates; Proposed Changes to the Ambulatory Surgical Center Payment System and CY 2009 Payment Rates*.

The proposed rule was released by the Centers for Medicare and Medicaid Services (CMS) on July 3, 2008, and is available for download at <http://edocket.access.gpo.gov/2008/pdf/E8-15539.pdf>. The agency will accept public comments until September 2, 2008. The provisions contained in this rule, if finalized, are applicable to services furnished on or after January 1, 2009.

### **For CY 2009**

The Social Security Act provides that the conversion factor update for the hospital outpatient prospective payment system (OPPS) is equal to the hospital inpatient market basket percentage increase applicable to hospital discharges. The proposed hospital market basket increase for FY 2009 published in the inpatient prospective payment system (IPPS) proposed rule is 3.0 percent.

After accounting for the proposed market basket increase update factor of 3.0 percent for CY 2009, the required wage index budget neutrality adjustment of approximately 1.0010, and the proposed adjustment of 0.02 percent of projected OPPS spending for the difference in the pass-through set aside, the proposed full market basket conversion factor for CY 2009 is \$65.684, compared to \$63.694 in CY 2008.

Major provisions of the OPPS rule follow.

## Charge Compression

- CMS concerned that Research Triangle International's (RTI's) March 2007 report on cost-to-charge ratios (CCR) was too limited, as it did not incorporate hospital outpatient services. Therefore, CMS contracted with RTI to evaluate the cost-estimation process for the OPPS relative weights; the report was published in July 2008.
- RTI's July 2008 report recommended longer-term accounting changes, and two sets of short-term recommendations to address charge compression:
  - Short-term accounting changes to current cost report data, and
  - Regression-based and other statistical adjustments.
- CMS is not proposing to adopt any short-term adjustments to OPPS payment rate calculations for CY 2009, and will "proceed cautiously" regarding any accounting changes – but is inviting comment regarding RTI's recommendations.

## PROPOSED UPDATES AFFECTING OPPS PAYMENTS

### *Proposed Calculation of Single Procedure Ambulatory Payment Classification (APC) Criteria-Based Median Costs*

#### Device-Dependent APCs

- CMS proposes to continue using its standard methodology for calculating median costs for device-dependent APCs (utilizing claims data that generally represent the device's full cost).
  - APCs 0106 (Insertion/Replacement of Pacemaker Leads and/or Electrodes), 0225 (Implantation of Neurostimulator Electrodes, Cranial Nerve), and 0418 (Insertion of Left Ventricular Pacing Electrode), have median decreases of 26 percent, 52 percent, and 47 percent, respectively.
    - CMS believes the decreases reflect hospitals' correction of inaccurate and incomplete billing practices for these services due to the implementation of device-to-procedure edits beginning in CY 2007.
  - The median cost for APC 0625 (Level IV Vascular Access Procedures) has decreased 59 percent; as a result, CMS proposes to map CPT code 36566 (Insertion of tunneled centrally inserted central venous access device, requiring two catheters via two separate venous access sites; with subcutaneous port(s)) – originally mapped to APC 0625 – to APC 0623 (Level III Vascular Access Procedures), which has a median cost of approximately \$1,939.

- The median cost of APC 0681 (Knee Arthroplasty) has decreased 19 percent. CMS believes this decrease is due to a low volume of services being performed by a small number of providers.

### **Blood and Blood Products**

- CMS proposes to continue to establish payment rates for blood and blood products using the blood-specific cost-to-charge ratio (CCR) methodology, which it has used since 2005.
- CMS proposes to create status indicator “R” (Blood and Blood Products), to facilitate development of blood product median costs under the blood-specific CCR methodology, and to facilitate implementation of the reduced payments that would be made to hospitals that fail to report hospital outpatient quality data.

### **Echocardiography Services**

- CMS proposes to continue the packaging of payment for all contrast agents into the payment for the associated imaging procedure (as in CY 2008).
- CMS proposes to continue estimating median costs for echocardiography services using the same methodology as in CY 2008.
- CMS proposes to set the CY 2009 payment rate for APC 0128 (Echocardiogram With Contrast) using the same methodology it used for CY 2008, as described in 72 Fed Reg 66645.

### **Nuclear Medicine Services**

- CMS is proposing to accept the following recommendations by the APC Panel made in 2008:
  - CMS should continue to package payment for diagnostic radiopharmaceuticals for CY 2009.
  - CMS should present data at the first CY 2009 APC Panel meeting on usage and frequency, geographic distribution, and size and type of hospitals performing nuclear medicine studies using radioisotopes to ensure that access to diagnostic radiopharmaceuticals is preserved for Medicare beneficiaries.
- CMS proposes to continue its CY 2008 methodology for setting the payment rates for APCs that include nuclear medicine procedures for CY 2009. The methodology has two steps, as follows:
  1. CMS uses an updated list of radiolabeled products from the procedure-to-radiopharmaceutical edit file to identify single and “pseudo”-single claims for nuclear medicine procedures that also included at least one eligible radiolabeled product.

2. Using this subset of claims, CMS follows its standard OPPS ratesetting methodology to calculate median costs for nuclear medicine procedures and associated APCs.
- The following APCs would be subject to the proposed payment methodology:

APC	APC Title
0307	Myocardial Positron Emission Tomography (PET) imaging
0308	Non-Myocardial Positron Emission Tomography (PET) imaging
0377	Level II Cardiac Imaging
0378	Level II Pulmonary Imaging
0389	Level I Non-Imaging Nuclear Medicine
0390	Level I Endocrine Imaging
0391	Level II Endocrine Imaging
0392	Level II Non-imaging Nuclear Medicine
0393	Hematologic Processing & Studies
0394	Hepatobiliary Imaging
0395	GI Tract Imaging
0396	Bone Imaging
0397	Vascular Imaging
0398	Level I Cardiac Imaging
0400	Hematopoietic Imaging
0401	Level I Pulmonary Imaging
0402	Level II Nervous System Imaging
0403	Level I Nervous System Imaging
0404	Renal and Genitourinary Studies
0406	Level I Tumor/Infection Imaging
0408	Level III Tumor/Infection Imaging
0414	Level II Tumor/Infection Imaging

### **Hyperbaric Oxygen Therapy**

- CMS proposes to use the same methodology it has used since CY 2005 to estimate a “per-unit” median cost for HCPCS code C1300 (Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval) of approximately \$103.

### *Proposed Calculation of Composite APC Criteria-Based Median Costs*

### **Radioimmunotherapy**

- CMS proposes to reject the APC Panel’s recommendation to develop a composite APC payment for radioimmunotherapy for CY 2009.

### **Multiple Imaging Services**

- CMS proposes to use the composite APC model for multiple imaging services by differentiating OPPS payment for the three imaging modalities (ultrasound, CT and CTA, and MRI and MRA) provided with contrast and without contrast.
  - The result would be five multiple imaging composite APCs in CY 2009:
    - 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 (MRI and MRA with Contrast Composite).
- The proposal would calculate the composite APC payment amounts from estimated costs on claims for multiple imaging services provided in a single session.
- To implement this 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 OPPS imaging family displayed in Table 8 (73 Feg Reg 41450-41451) on a single date of service.

### **Established Composite APCs**

- CMS proposes to continue its composite APC policies for the following services:
  - Extended assessment and management (APCs 8002 and 8003),
  - Low dose rate (LDR) prostate brachytherapy (APC 8001),
  - Cardiac electrophysiologic evaluation and ablation (APC 8000), and
  - Mental health services (APC 0034).

## *Proposed Changes to Packaged Services*

### **Service-Specific Packaging Issues**

- CMS proposes to adopt the following recommendations of the Packaging Subcommittee of the APC Panel:
  - To provide additional data to support packaging radiation oncology guidance services for review by the Data Subcommittee at the next APC Panel meeting.
  - To treat CPT code 36592 (Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified) as an “STVX-packaged code,” and assign it to APC 0624 (Phlebotomy and Minor Vascular Access Device Procedures).
  - To maintain the unconditionally packaged status of HCPCS code A4306 (Disposable drug delivery system, flow rate of less than 50 mL per hour), because it represents a supply, and payment of supplies is packaged under the OPPS.
  - To treat CPT code 74305 (Cholangiography and/or pancreatography; through existing catheter, radiological supervision and interpretation) as a “T-packaged code,” and assign it to APC 0263 (Level I Miscellaneous Radiology Procedures).
  - To maintain the packaged status of diagnostic radiopharmaceuticals (as discussed earlier in this summary).
- CMS proposes not to adopt the following recommendation of the Packaging Subcommittee of the APC Panel:
  - To reinstate separate payment for the following intravascular ultrasound and intracardiac echocardiography CPT codes:
    - 37250 (Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; initial vessel);
    - 37251 (Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; each additional vessel);
    - 92978 (Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel);
    - 92979 (Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; each additional vessel); and

- 93662 (Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation).
- Instead, CMS proposes to maintain the unconditionally packaged status of CPT codes 37250, 37251, 92978, 92979, and 93662.

### **IVIG Preadministration-Related Services**

- CMS proposes to package payment for HCPCS code G0332 (Services for intravenous infusion of immunoglobulin prior to administration (this service is to be billed in conjunction with administration of immunoglobulin)) for CY 2009.
- The proposal is based on the following reasons:
  - Because HCPCS code G0332 meets CMS' historical criteria for packaged payment,
  - Because CMS paid separately for these services on a temporary basis only, and
  - Because CMS believes that the reported transient market conditions that led the agency to adopt the separate payment for IVIG preadministration-related services have improved.

### *Proposed Conversion Factor Update*

CMS is required to update the conversion factor used to determine payment rates under the OPSS on an annual basis. For CY 2009, the update is equal to the hospital inpatient market basket percentage increase. The proposed hospital market basket increase for FY 2009 is 3.0 percent.

To set the proposed OPSS conversion factor for CY 2009, CMS increased the CY 2008 conversion factor of \$63.694 by 3.0 percent. Hospitals that fail to meet the reporting requirements of the Hospital Outpatient Quality Data Reporting (HOP QDRP) program are subject to a reduction of 2.0 percentage points.

CMS further adjusts the conversion factor annually to ensure that any proposed updates for a revised wage index and rural adjustment are made on a budget-neutral basis. For CY 2009, CMS calculated an overall budget-neutrality factor of 1.0010 for wage index changes, and is not proposing a change to the rural adjustment policy; therefore, the budget-neutrality factor for the rural adjustment is 1.000.

For CY 2009, CMS estimates that allowed pass-through spending for drugs, biologicals, and devices would equal approximately \$19 million, which represents 0.07 percent of total projected OPSS spending for CY 2009. Therefore, CMS adjusted the conversion factor by the difference between the 0.09 percent pass-through dollars

set aside for CY 2008, and the 0.07 percent estimate for CY 2009 pass-through spending.

Proposed payments for outliers remain at 1.0 percent of total OPSS payments.

The various adjustments result in a proposed full market basket conversion factor for CY 2009 of \$65.684. To calculate the CY 2009 reduced market basket conversion factor for hospitals that fail to meet the requirements of the HOP QDRP for the full CY 2009 payment update, CMS made all other adjustments, but used a reduced market basket increase update factor of 1.0 percent. This results in a proposed reduced market basket conversion factor for CY 2009 of \$64.409.

### *Proposed Wage Index Changes*

CMS proposes to use the final FY 2009 IPPS wage indices for calculating the OPSS payments.

### *Proposed Hospital Outpatient Outlier Payments*

For CY 2009, CMS proposes to continue its policy of setting aside 1.0 percent of aggregate total payments under the OPSS for outlier payments. CMS proposes that 0.07 percent of the set-aside would be allocated to community mental health centers for partial hospitalization program outlier payments.

To ensure that estimated CY 2009 aggregate outlier payments would equal 1.0 percent of estimated aggregate total payments under the OPSS, CMS proposes to set the hospital outlier threshold so that outlier payments would be triggered 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 an \$1,800 fixed-dollar threshold.

### *New Technology APCs*

## **Proposed Movement of Procedures from New Technology APCs to Clinical APCs**

- CMS proposes to move the following HCPCS codes from new-technology APCs to clinically-appropriate APCs:
  - C9725 (Placement of endorectal intracavitary applicator for high intensity brachytherapy),
  - C9726 (Placement and removal (if performed) of applicator into breast for radiation therapy), and
  - C9727 (Insertion of implants into the soft palate; minimum of three implants).

- CMS proposes to delete HCPCS code C9723 (Dynamic infrared blood perfusion imaging (diri)), due to lack of utilization.

### *Proposed OPPS APC-Specific Policies*

#### **Suprachoroidal Delivery of Pharmacologic Agent (APC 0236)**

- CMS proposes to reassign CPT code 0186T (Suprachoroidal delivery of pharmacologic agent (does not include supply of medication)) from APC 0236 (Level II Posterior Segment Eye Procedures) to APC 0237 (Level III Posterior Segment Eye Procedures).

#### **Closed Treatment of Fracture of Finger/Toe/Trunk (APC 0043)**

- CMS proposes to replace APC 0043 (Closed Treatment Fracture Finger/Toe/Trunk) with three new APCs:
  - 0129 (Level I Closed Treatment Fracture Finger/Toe/Trunk),
  - 0138 (Level II Closed Treatment Fracture Finger/Toe/Trunk), and
  - 0139 (Level III Closed Treatment Fracture Finger/Toe/Trunk).

#### **Individual Psychotherapy (APCs 0322 and 0323)**

- CMS proposes to assign status indicator “P” (Services may be billed appropriately and paid under the OPPS only when part of a partial hospitalization program) to CPT codes 90816 through 90829, indicating that these services may be billed appropriately and paid under the OPPS only when they are part of a partial hospitalization program.
- Under this proposal, hospitals would continue to report CPT codes 90804 through 90815 for individual psychotherapy services provided in the hospital outpatient department that are not part of partial hospitalization services, consistent with CPT instructions.

#### **Implant Injection for Vesicoureteral Reflex (APC 0162)**

- CMS proposes to reassign CPT code 52327 (Cystourethroscopy, including ureteral catheterization, with subureteric injection of implant material) from APC 00162 (Level III Cystourethroscopy and other Genitourinary Procedures) to APC 0163 (Level IV Cystourethroscopy and other Genitourinary Procedures).

## **PROPOSED OPPS PAYMENT FOR DEVICES**

### *Pass-Through Payments for Devices*

#### **Expiration of Transitional Pass-Through Payments for Certain Devices**

- CMS has no established device categories eligible for pass-through payment that are continuing into CY 2009.

### *Proposed Adjustment to OPPS Payment for Partial or Full Credit Devices*

- CMS proposes to continue reducing OPPS payment by 1) 100 percent of the device offset amount when a hospital furnishes a specified device without cost or with a full credit, and 2) by 50 percent of the device offset amount when the hospital receives partial credit in the amount of 50 percent or more of the cost for the device.
- CMS proposes to continue using the three criteria below for determining the APCs to which this policy applies:
  1. All procedures assigned to the selected APCs must require implantable devices that would be reported if device insertion procedures were performed;
  2. The 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. The device offset amount must be significant, which is defined as exceeding 40 percent of the APC cost.
- CMS proposes to continue to restrict the devices to which the APC payment adjustment would apply to a specific set of costly devices to ensure that the adjustment would not be triggered by the implantation of an inexpensive device whose cost would not constitute a significant proportion of the total payment rate for an APC.

## **PROPOSED OPPTS PAYMENT CHANGES FOR DRUGS, BIOLOGICALS, AND RADIOPHARMACEUTICALS**

### *Proposed OPPTS Transitional Pass-Through Payment for Additional Costs of Drugs, Biologicals, and Radiopharmaceuticals*

#### **Proposed Drugs and Biologicals With Expiring Pass-Through Status in CY 2008**

- CMS proposes to package payment for any biological without pass-through status that is surgically inserted or implanted (through a surgical incision or a natural orifice) into the payment for the associated surgical procedure.
  - As a result of this proposed methodology, the following HCPCS codes with expiring pass-through status would be packaged and assigned status indicator “N” (Items and Services Packaged into APC Rates):
    - C9352 (Neuragen nerve guide, per cm),
    - C9353 (Neurawrap nerve protector, cm),
    - J3473 (Hyaluronidase recombinant), and
    - J7348 (Tissuemend tissue).
- The following HCPCS codes with expiring pass-through status would be assigned status indicator “K” (Nonpass-Through Drugs and Biologicals. Paid under OPPTS; separate APC payment.), and CMS would provide separate payment at the applicable relative average sales price (ASP)-based payment amount (proposed at ASP+4 percent for CY 2009):
  - J0129 (Abatacept injection),
  - J0348 (Anadulafungin injection),
  - J0894 (Decitabine injection),
  - J1740 (Ibandronate sodium injection),
  - J1743 (Idursulfase injection),
  - J2248 (Micafungin sodium injection),
  - J2323 (Natalizumab injection),
  - J2778 (Ranibizumab injection),
  - J3243 (Tigecycline injection),
  - J7349 (Primatrix tissue), and
  - J9303 (Panitumumab injection).

**Proposed Drugs, Biologicals, and Radiopharmaceuticals With New or Continuing Pass-Through Status in CY 2009**

- CMS proposes to continue pass-through status for the following drugs:

CY 2009 HCPCS Code	Descriptor	Proposed CY 2009 APC
C9238	Inj, levetiracetam	9238
C9239	Inj, temsirolimus	1168
C9240	Injection, ixabepilone	9240
C9241	Injection, doripenem	9241
C9242	Injection, fosaprepitant	9242
C9354	Veritas collagen matrix, cm <sup>2</sup>	9354
C9355	Neuromatrix nerve cuff, cm	9355
C9356	TenoGlide Tendon Prot, cm <sup>2</sup>	9356
C9357	Flowable Wound Matrix, 1 cc	9357
C9358	SurgiMend, 0.5 cm <sup>2</sup>	9358
J1300	Eculizumab injection	9236
J1571	HepaGam B IM Injection	0946
J1573	Hepagam B intravenous, inj	9356
J3488	Reclast injection	0951
J9226	Supprelin LA implant	1142
J9261	Nelarabine injection	0825

**Proposed Reduction of Transitional Pass-Through Payments for Diagnostic Radiopharmaceuticals To Offset Costs Packaged Into APC Groups**

- CMS has a methodology to estimate the portion of each APC payment rate that could reasonably be attributed to the cost of an associated device eligible for pass-through payment (the APC device offset amount) to avoid duplicate payment for the device portion of a procedure.
- CMS evaluates new pass-through device categories individually to determine if there are device costs packaged into the associated procedural APC payment rate from predecessor devices that resemble the new pass-through device category, suggesting that a device offset amount would be appropriate.

- CMS proposes the following APCs to which nuclear medicine procedures are proposed for assignment in CY 2009, and for which an APC radiopharmaceutical offset could be applicable in the case of new diagnostic radiopharmaceuticals with pass-through status.

APC	APC Title
0307	Myocardial Positron Emission Tomography (PET) imaging
0308	Non-Myocardial Positron Emission Tomography (PET) imaging
0377	Level II Cardiac Imaging
0378	Level II Pulmonary Imaging
0389	Level I Non-imaging Nuclear Medicine
0390	Level I Endocrine Imaging
0391	Level II Endocrine Imaging
0392	Level II Non-imaging Nuclear Medicine
0393	Hematologic Processing & Studies
0394	Hepatobiliary Imaging
0395	GI Tract Imaging
0396	Bone Imaging
0397	Vascular Imaging
0398	Level I Cardiac Imaging
0400	Hematopoietic Imaging
0401	Level I Pulmonary Imaging
0402	Level II Nervous System Imaging
0403	Level I Nervous System Imaging
0404	Renal and Genitourinary Studies
0406	Level I Tumor/Infection Imaging
0408	Level III Tumor/Infection Imaging
0414	Level II Tumor/Infection Imaging

- The APC radiopharmaceutical offset amount would be calculated based on a percentage of the APC payment for a nuclear medicine procedure attributable to the costs of packaged diagnostic radiopharmaceuticals.

*Proposed OPPS Payment for Drugs, Biologicals, and Radiopharmaceuticals Without Pass-Through Status*

**Proposed Criteria for Packaging Payment for Drugs, Biologicals and Radiopharmaceuticals**

- CMS proposes a packaging threshold of \$60 for drugs and biologicals, which is unchanged from CY 2008.
- CMS proposes to continue to exempt the oral and injectable forms of 5HT<sub>3</sub> anti-emetic products from packaging for CY 2009, thereby making separate payment for all 5HT<sub>3</sub> anti-emetic products.
- CMS proposes to continue packaging payment for all nonpass-through diagnostic radiopharmaceuticals and contrast agents for CY 2009, regardless of their per-day costs.

*Proposed Payment for Drugs and Biologicals Without Pass-Through Status That Are Not Packaged*

**Payment for Specified Covered Outpatient Drugs (SCODs)**

- CMS proposes to pay for the combined average acquisition and pharmacy overhead cost of separately payable drugs and biologicals at ASP+4 percent under the CY 2009 OPPS.
- Comments from the hospital industry indicate that differential hospital markup policies related to the cost of an item lead to overestimating the cost of inexpensive items and underestimating the cost of expensive items when a single CCR is applied to charges on claims.
  - These charging practices for pharmacy overhead costs resemble the charge compression for expensive implantable devices.
- To address the differential hospital markup policies, CMS proposes to create two new cost centers when it revises the Medicare hospital cost report form; specifically:
  - Drugs with High Overhead Cost Charged to Patients, and
  - Drugs with Low Overhead Cost Charged to Patients.
- CMS invites comment on the policy and operational benefits, challenges, and concerns that may be associated with these proposals, specifically as they relate to the proposed approach to distinguishing between drugs and biologicals for purposes of inclusion in the two proposed new cost centers.

### **Proposed Payment for Blood Clotting Factors**

- CMS proposes to pay for blood clotting factors at ASP+4 percent, consistent with its proposed payment policy for other nonpass-through separately payable drugs and biologicals.
- CMS proposes to continue its policy for paying the furnishing fee using an updated amount for CY 2009.
  - CMS is unable to include the actual updated furnishing fee in the proposed rule, and will announce the actual figure for the furnishing fee through program instructions and posting on the CMS website.

### *Proposed Payment for Therapeutic Radiopharmaceuticals*

- CMS proposes to pay for therapeutic radiopharmaceuticals at the ASP rate, if ASP information is available for a given calendar year quarter.
- If ASP information is not available, CMS proposes to provide payment based on the most recent hospital mean unit cost data available.
- CMS requests comment on the development of a crosswalk for therapeutic radiopharmaceuticals.

### *Proposed Payment for Nonpass-Through Drugs, Biologicals, and Radiopharmaceuticals With HCPCS Codes, but Without OPPS Hospital Claims Data*

- CMS proposes to provide payment for new drugs and biologicals with HCPCS codes, but which do not have pass-through status and are without OPPS hospital claims data, at ASP+4 percent. This payment policy is consistent with the CY 2009 proposed payment methodology for other separately payable nonpass-through drugs and biologicals.
- CMS proposes, in the absence of ASP data, to use the product's wholesale acquisition cost (WAC) to establish the initial payment rate for new nonpass-through drugs and biologicals with HCPCS codes, but which are without OPPS claims data.
  - CMS notes that, if the WAC is also unavailable, payment would be made at 95 percent of the product's most recent AWP.
- CMS proposes to assign status indicator "K"<sup>1</sup> to HCPCS codes for new drugs and biologicals that do not have submitted pass-through applications.
- CMS proposes to base payment for new therapeutic radiopharmaceuticals with HCPCS codes as of January 1, 2009, but which do not have pass-through status, on the products' WACs, if ASP data are not available.

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<sup>1</sup> Status indicator "K" = Non-Pass-Through Drugs and Biologicals. Paid under OPPS; separate APC payment.

- If the WACs are also unavailable, CMS would pay for new therapeutic radiopharmaceuticals at 95 percent of their most recent average wholesale prices.
- CMS proposes to assign status indicator “K” to HCPCS codes for new therapeutic radiopharmaceuticals that do not have submitted pass-through applications.

### **PROPOSED OPSS PAYMENT FOR BRACHYTHERAPY SOURCES**

- CMS proposes to establish new status indicator “U” (Brachytherapy Sources. Paid under OPSS; separate APC payment) for brachytherapy sources.
- CMS proposes to pay for brachytherapy sources at prospective rates based on their source-specific median costs for CY 2009.
- CMS proposes to assign future new HCPCS codes for new brachytherapy sources to their own APCs, with prospective payment rates set based on consideration of external data and other information regarding the expected costs of the sources to hospitals.

### **PROPOSED OPSS PAYMENT FOR DRUG ADMINISTRATION SERVICES**

- CMS proposes a five-level APC structure for CY 2009 drug administration services to reflect resource utilization more appropriately in APCs that also group clinically similar services.
  - CMS believes the proposed APCs demonstrate the clinically-expected and actually-observed comparative relationships between the median costs of different types of drug administration services, including:
    - Initial and additional services;
    - Chemotherapy and other diagnostic, prophylactic, or therapeutic services;
    - Injections and infusions; and
    - Simple and complex methods of drug administration.

- The proposed five-level APC structure is as follows:

Proposed CY 2009 APC	Proposed CY 2009 APC median cost
0436	\$24.98
0437	\$36.59
0438	\$74.19
0439	\$126.58
0440	\$190.72

**PROPOSED PROCEDURES THAT WILL BE PAID ONLY AS INPATIENT PROCEDURES**

- CMS proposes that the following 11 procedures be removed from the OPPI inpatient list for CY 2009, and be assigned to clinically appropriate APCs.

HCPSC Code	Descriptor	Proposed CY 2009 APC
20660	Application of cranial tongs caliper, or stereotactic frame, including removal (separate procedure)	0138
21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)	0256
21386	Open treatment of orbital floor blowout fracture; periorbital approach	0256
21387	Open treatment of orbital floor blowout fracture; combined approach	0256
27479	Arrest, epiphyseal, any method (e.g., epiphysiodesis); combined distal femur proximal tibia and fibula	0550
27886	Amputation, leg, through tibia and fibula; reamputation	0049

HCPCS Code	Descriptor	Proposed CY 2009 APC
43420	Closure of esophagostomy or fistula; cervical approach	0254
50727	Revision of urinary-cutaneous anastomosis (any type urostomy)	0165
54332	One stage proximal penile or penoscrotal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap	0181
54535	Orchiectomy, radical, for tumor; with abdominal exploration	0181
61850	Twist drill or burr hole(s) for implantation of neurostimulator electrodes, cortical	0061