Hospitals could receive Medicare payment for outpatients who have certain spinal surgeries, balloon valvuloplasty, placement of an epidural catheter with laminectomy, and other procedures previously defined as inpatient only.

These are among changes proposed for the hospital outpatient prospective payment system (OPPS) for 2003. Hospitals also need to make sure their charging systems for device pass-throughs are up to date. Pass-through payments are expiring for 95 device categories, and the government is proposing to reject line items with C codes for these devices after Jan 1.

The Centers for Medicare and Medicaid Services (CMS) published the proposed changes Aug 9, and comments are due Oct 7. The updates are scheduled to take effect Jan 1.

The proposed changes affect other procedures previously defined as inpatient only.

Inpatient procedures proposed for outpatient payment

In all, 41 CPT codes from the inpatient-only list are being proposed for outpatient payment. Major ones are certain spinal procedures involving partial excision of a vertebral component (CPT 22100, 22101, 22102, and 22103), repair of nonunion or malunion of the radius or ulna (CPT 25420), implantation, revision, or repositioning of a tunneled intrathecal or epidural catheter for long-term medication administration with laminectomy (CPT 62351), percutaneous balloon valvuloplasty (CPT 92986, 92987, and 92990) and angioplasty of the pulmonary artery (CPT 92997 and 92998).

CMS also recommended removing from the inpatient list CPT 47001, Biopsy of the liver, because it is often billed with procedures that are billable as outpatient. But the status indicator would be changed to N, meaning the payment would be bundled into the APC payment, and there no longer would be separate reimbursement.

Although Medicare’s APC advisory panel recommended doing away with the inpatient list and leaving the decision about where to do the procedure to the patient’s physician, CMS disagrees.

The list of inpatient procedures proposed for outpatient payment is on the OR Manager web site at www.ormanager.com

Drug-eluting stents

CMS is taking the unprecedented step of proposing a new APC and two new payment codes for drug-eluting coronary artery stents, even though they have not yet been approved by the Food and Drug Administration (FDA) for general use. Approval could come as early as the end of this year.

Drug-eluting stents, which have been developed to combat restenosis of blood vessels, potentially could transform the treatment of coronary artery disease.

Once the stents are approved, patients will begin to demand them, and hospitals could face financial hardship if there is no payment mechanism.

Therefore, CMS is proposing to create a new APC 656 and two new HCPCS codes for drug-eluting stents. CMS did the same for inpatient payment this fall when it created two new DRGs for the stents. These new codes could be used for billing if the stents receive FDA approval.

The proposed payment rate of $1,200 is based on experience with the stents in Europe. This payment mechanism would be temporary and would expire in 2005 when a long-term payment strategy will be introduced.

Experts say the stents actually could save Medicare costs in the long run if fewer patients need repeat angioplasties or bypass surgery.

The new codes would take effect April 1, 2003. If the drug-eluting stents are approved before then, they will be paid under APC 104.

Ordinarily, additional payment on a new technology isn’t available until CMS has had a chance to collect charge data on its costs, which typically takes 2 years.

Emergency surgery

Hospitals have wondered how they can receive Medicare payment for a procedure on the inpatient list for a patient who had to be resuscitated or stabilized, then was transferred or died before he or she could be admitted.

The proposed rule clarifies what must be in the medical record for a hospital to receive payment and how these claims should be handled. See Aug 9 Federal Register, p 52137.

Pass-through payments

Pass-through payments are temporary additional payments for APCs whose payment rates may not adequately reflect the cost of certain devices, drugs, and biologicals. CMS says the...
pass-through payments have been “exceptionally difficult to implement”— perhaps the most complex and difficult in the history of Medicare.

Pro-rata reduction. CMS said it has not yet completed estimates to know whether a pro-rata reduction in pass-through payments will be necessary. By law, pass-through payments for 2003 are not supposed to exceed 2.5% of the total payments for hospital OPPS. If spending is projected to exceed that, CMS can make a pro-rata reduction in payments.

Devices with expiring pass-through payments. Some 95 device categories are due to expire Jan 1, and CMS is proposing to reject line items that have a C code for these categories after Jan 1. Examples are a number of kinds of catheters including electrophysiology catheters as well as cochlear implant systems, human connective tissue, pacemakers, pacemaker leads, and other types of leads.

Instead, the cost for these items would be bundled into the cost of the procedures with which they were billed in 2001. Hospitals would submit charges for surgically inserted devices in the revenue center that most closely describes the implant.

The categories are expiring because by law pass-through payments can not be made for more than 3 years.

2003 payment rates. CMS is warning that pass-through rates for some devices and drugs are “significantly different” from the 2002 rates—some higher and some lower. That’s because CMS has had time to collect more data on hospital charges. Rates in the past have been based on device manufacturers’ list prices.

One procedure that will have a dramatically lower payment is APC 108 (insertion/placement/repair of cardioverter-defibrillator leads).

CMS is asking for comment because it is concerned the payment reductions could have an impact on access to care.

CMS is not sure if some of the rates are correct because, with the complexity of the system, hospitals may not have always billed for the device as part of the claim, and CMS’s data may be incomplete.

Device offsets for pass-through payments. A total of 60 APCs will have their device-related pass-through payments adjusted. The pass-through payment will be reduced by the amount of the APC payment that CMS estimates is represented by the device. This is to avoid duplicate payment for the device.

For example, for APC 82, coronary arthrectomy, CMS estimates that 47.58% of the payment is related to the device.

Thus, CMS will apply a formula to reduce the pass-through payment by that amount.

Brachytherapy. In 2003, for two types of services, CMS proposes packaging brachytherapy seeds into the APC payment:

• remote afterloading high intensity brachytherapy
• prostate brachytherapy.

Most brachytherapy claims are for prostate.

For other brachytherapy services, packaging of the seeds would be deferred for at least 1 year. For these for 2003, CMS proposes to continue paying on a per-seed basis, according to the median cost.

A list of the inpatient-only procedures proposed for outpatient payment is on the OR Manager web site at www.ormanager.com

Summary prepared by OR Manager, Inc. 800/442-9918.