



ASNC Summary of 2011 Hospital Outpatient Prospective Payment System Proposed Rule

The Centers for Medicare & Medicaid Services (CMS) released the proposed 2011 Hospital Outpatient Prospective Payment System (HOPPS) on July 2, 2010. This regulation includes proposals and policies impacting hospital outpatient and ambulatory surgical center (ASC) services paid under the outpatient prospective and ASC payment systems.

Comparison of Reimbursement Rates (2010 vs. 2011)

Appendix 1 compares reimbursement rates from the 2010 HOPPS **final rule** and the 2011 HOPPS **proposed rule**. The proposed rule includes a minor reduction in reimbursement for nuclear cardiology services and more significant cuts for cardiac PET. The proposed rule includes a 0.25 percent reduction as required by law from the Affordable Care Act, and certain hospitals that did not meet quality reporting requirements would face additional 2 percent reductions in payment.

ASNC will submit comments to CMS on the proposed rule, which is scheduled to be published in the Federal Register on August 3, 2010.

Key Provisions from the 2011 Proposed HOPPS

Radiopharmaceuticals

- **CMS continues to package payments for all diagnostic radiopharmaceuticals and contrast agents** with the major procedure payment, regardless of their per-day costs. CMS comments in the rule that they have analyzed the volumes and since there are no significant changes, they assume there is no negative effect from packaging diagnostic radiopharmaceuticals. Claims from 2007 to 2009 showed a 1 percent increase in volume.
- **Transitional pass-through (new) drugs, biological, diagnostic radiopharmaceuticals, and contrast agents** for 2011 include HCPCS Level II code A9852 Iobenguane, I-123, dx, per study dose, up to 15 millicuries. This diagnostic radiopharmaceutical continues pass-through status in 2011. CMS did not propose any changes to transitional pass-through policies for 2011.
 - CMS proposed to **continue their “offset” policy** in 2011 for packaged diagnostic radiopharmaceuticals or contrast agents when separately paid under the transitional pass-through policies. According to CMS, the payment offset is needed to ensure that no duplicate payment for radiopharmaceutical costs is made to hospitals.
- **CMS proposes to use a “FB” modifier policy when hospitals receive “free/full credit” radiopharmaceuticals.** The Integrated Outpatient Code Editor includes edits that require a hospital to report a diagnostic radiopharmaceutical with a nuclear medicine scan in order to receive payment for the nuclear medicine scan. CMS notes that hospitals have asked how to bill for a nuclear medicine scan when the hospital receives a diagnostic radiopharmaceutical free of charge or with full credit. To clarify

this policy, CMS proposes to instruct hospitals to report the “FB” modifier on the line with the procedure code for the nuclear medicine scan in which the no cost/full credit diagnostic radiopharmaceutical is used.

Modifier –FB is described as an “Item Provided Without Cost to Provider, Supplier or Practitioner, or Credit Received for Replacement Device (Examples, but not Limited to: Covered Under Warranty, Replaced Due to Defect, Free Samples).” While CMS points out that this modifier is specific to devices, CMS believes that “it captures the concept of the hospital receiving a key component of the service without cost.” In those cases in which the diagnostic radiopharmaceutical is furnished without cost or with full credit, CMS proposes to instruct the hospital to report a token charge of less than \$1.01. When a hospital bills an –FB with the nuclear medicine scan, the payment amount for procedures would be reduced by the full “policy-packaged” offset amount appropriate for the diagnostic radiopharmaceutical.

- Separately payable **drugs and biological agents without pass-through status** (including pharmacy overhead) are proposed to be paid at **106 percent of the Average Sales Price (ASP)** rather than the current rate of 104 percent of ASP. The ASP plus 6 percent would be in line, if implemented, with the office and independent diagnostic testing facility payment rates. CMS cautions that when the full data is available for the final rule, the percentage could change based on the defined methodology in the rule.
- CMS proposed to increase the drug threshold for paying separately for drugs, biological agents, and therapeutic radiopharmaceuticals. The current threshold is \$65, and CMS proposes to raise this to drugs costing \$70 or more per day. Payments for drugs at or below the threshold will continue to be bundled into payments for their associated procedures.

Multiple Imaging Services on Same Day of Service

- CMS proposes to continue packaging, without modification, multiple imaging services (an extension of “composites”) provided in one session. Modalities affected are computed tomography (CT) and cardiac CT angiography, magnetic resonance imaging (MRI and MRA), and ultrasound services. Nuclear medicine is not one of the modalities affected by this policy. Under the policy, CMS would make a single payment for multiple services on the same day of service of the identified modalities through five imaging composite APC groups. This continued policy is intended to encourage imaging efficiencies, similar to the multiple-procedure reduction currently implemented in the office and independent diagnostic testing facility settings.

Reporting of Quality Measures

- CMS is proposing to expand the set of measures that must be reported by Hospital Outpatient Departments to qualify for the full payment update in the succeeding year. The proposed rule includes proposals for additions to the set for reporting in 2011, 2012, and 2013 to make it easier for hospitals and the agency to prepare for the changing reporting requirements. **Hospitals that fail to report these measures would incur a 2 percent reduction in their annual HOPPS payment update factor for 2011.** The reduction would not apply to payment for separately payable non-pass-through drugs and non-implantable biologicals and services assigned to new technology APCs. **One important proposed new quality measure for 2011 is use of stress echocardiography, SPECT MPI, and cardiac stress MRI post-CABG.**

Additional Resources

[2011 Hospital Outpatient Prospective Payment System Proposed Rule - Regulation as Published by CMS](#)

Appendix 1: Hospital Outpatient Prospective Payment System 2010 Final Rates vs. 2011 Proposed Rates

This table compares the proposed 2011 HOPPS rates with the final 2010 HOPPS rates for codes relevant to nuclear cardiology. Payment rates for diagnostic nuclear medicine procedures include the payment for diagnostic radiopharmaceuticals. ASNC will provide comments to the Centers for Medicare & Medicaid Services (CMS) during the 60-day comment period, and the final rule is scheduled for release in November 2010.

CPT/HCPCS	Description	2010 Final HOPPS Rate	2011 Proposed HOPPS Rate	Change (%)
78451-2	MPI, SPECT, single or multiple studies	\$773.20	\$768.38	-1%
78453-4	Ht muscle image, planar, single & multiple	\$773.20	\$768.38	-1%
78459	Heart muscle imaging (PET)	\$1,429.36	\$1,099.16	-23%
78491-2	Heart image PET, single & multiple	\$1,429.36	\$1,099.16	-23%
75571	Ct hrt w/o dye w/ ca test	\$45.00	\$47.10	+5%
75572	Ct hrt w/ 3d image	\$224.19	\$258.02	+15%
75573	Ct hrt w/ 3d image, congen	\$325.22	\$258.02	-21%
75574	Ct angio hrt w/ 3d image	\$268.49	\$258.02	-4%
93017	Cardiovascular stress test	\$175.74	\$179.55	+2%