Medicare's Final Outpatient Rule Boosts Device Payments

BY ALICIA AULT
Associate Editor, Practice Trends

The Centers for Medicare and Medicaid Services will increase payments for outpatient services by an average of 3.8% in 2008, with most of the neurologic, cardiac, and gynecologic procedures covered under the payment system being slated for small to moderate increases.

Overall, hospitals will be paid about $36 billion in 2008, a 10% increase from 2007, and $1 billion more than was estimated in the proposed outpatient rule, according to CMS.

The 2008 Hospital Outpatient Prospective Payment System final rule also includes a revised method of paying for services in ambulatory surgical centers. Starting in 2008, services performed in ASCs will be reimbursed at 65% of the rate paid for the same service in an outpatient hospital department. This rate is unchanged from the proposed rule.

"The revised system takes a major step toward eliminating financial incentives for choosing one care setting over another, thereby placing patients' needs first, increasing efficiencies, and leading to savings for both beneficiaries and the Medicare program," said CMS Acting Administrator Kerry Weems.

Hospitals will be required to report on seven quality measures, including five emergency department measures pertaining to transfer of acute myocardial infarction patients, and two surgical care improvement measures. Under the proposed rule, hospitals were going to be required to report on 10 measures. Three were dropped in the final rule: administration of an ACE inhibitor to heart failure patients, empiric antibiotics for community-acquired pneumonia, and hemoglobin A_{1c} control. Now, if hospitals do not report on the seven measures, they will get an automatic 2% reduction in inpatient pay in 2009, according to CMS.

CMS also said it was issuing three new composite ambulatory payment classification (APC) groups. The APC bundles frequently performed procedures into a single payment, thus creating an episode-of-care-based payment. The new APCs in the final rule are for extended outpatient visits with observation, low dose–rate prostate brachytherapy, and cardiac electrophysiologic evaluation and ablation.

The agency is continuing its policy of bundling payments for certain ancillary services, to create efficiencies and to give hospitals more flexibility to manage costs. Some of the services that will now be covered by a bundled payment include image processing services, intraoperative services, and imaging supervision and interpretation services.

Most cardiac procedures are slated for an increase—1.9% for pacemaker insertion, 5.2% for bare metal stents, and 13.3% for drug-eluting stents.

Dr. Kim Allan Williams, nuclear cardiology director at the University of Chicago, said bundled payments can often mean that a service is not properly reimbursed. But under the outpatient payment system, CMS has found a way to make sure that every service is appropriately covered, said Dr. Williams in an interview.

Most cardiac procedures are slated for an increase—from a modest 1.9% for pacemaker insertion or replacement, to 5.2% for bare metal stents, to 13.3% for drug-eluting stents. Implantation of left ventricular pacing leads (add-on) will be cut by 12.4%, but that comes on the heels of 3 years of 80%-180% increases.

Some neurologic device implant procedures will also see a reimbursement increase. Neurostimulators, used primarily for lessening of symptoms of movement disorders such as Parkinson's disease and essential tremor, as well as control of epilepsy and pain, are slated for a 3.1% increase. The electrodes required with the devices will see a 3.4% rise in payment.

The changes aren't enough to have any impact on the numbers of these procedures being done, said Dr. Rajesh Pahwa, director of the Parkinson's Disease and Movement Disorder Center at the University of Kansas, Kansas City. For gynecologic procedures, endometrial ablation will get a 17.9% increase in pay, and surgical hysteroscopy a 4.2% increase. ■

Criteria for Coverage of Sleep Apnea Devices May Be Eased

BY MARY ELLEN SCHNEIDER
New York Bureau

Medicare may soon begin providing coverage for continuous positive airway pressure devices for beneficiaries who have been diagnosed with obstructive sleep apnea using unattended home monitoring.

The coverage proposal is an expansion of Medicare's current policy, which provides coverage for continuous positive airway pressure (CPAP) only when a diagnosis of obstructive sleep apnea (OSA) has been confirmed using polysomnography in a sleep laboratory.

"Our proposed policy to extend coverage for continuous positive airway pressure provides more options for Medicare beneficiaries and their treating physicians," Kerry Weems, acting administrator for the Centers for Medicare and Medicaid Services, said in a statement.

The CMS released the proposal in December, and officials at the agency plan to issue a final national coverage determination in March 2008. Medicare officials estimate that as many as 4 million Medicare beneficiaries suffer from OSA.

The CMS proposal would extend coverage in cases where the diagnosis was made as a result of a combination of a clinical evaluation and unattended home sleep monitoring using a type II, III, or IV device.

In addition, Medicare is proposing to cover CPAP when the diagnosis of OSA is made through a clinical evaluation or another type of diagnostic test, as long as the patient is participating in a research study that meets CMS standards for clinical trial policy.

The current proposal "as is" is likely to result in a "wasteful use of resources" and could hurt patients, said Dr. Robert Thomas of Beth Israel Deaconess Medical Center in Boston. Single channel sleep monitoring devices have many problems, including false-negative results, said Dr. Thomas, who holds patents for technology to estimate sleep quality from an ECG and for CO_2 use in mixed sleep apnea treatment.

However, Dr. Thomas said, the CMS final policy is likely to be more sensible. "I do believe that doing all studies in the lab is not cost, time, or effort efficient," he said. "So there is much merit in a sensible, best-science driven portable recording policy."

The CMS also plans to limit coverage for the CPAP devices to an initial 12-week period to gauge whether the patient will respond to the treatment. Medicare will continue to cover use of the CPAP in those patients who respond to the treatment.

In addition, the CMS is planning to eliminate the requirement for a minimum 2 hours of continuous recorded sleep during testing, because patients with severe OSA may not be able to meet the requirement.

Dr. Thomas praised this aspect of the proposal, because some patients with severe disease and badly fragmented sleep never reach the sleep threshold quickly enough to conduct an air pressure titration on the same night.

The CMS based its decision on advice from the Medicare Evidence Development and Coverage Advisory Committee, external technology assessments from the Agency for Healthcare Research and Quality, a review of individual clinical studies, and public comments.

Agency officials concluded that the evidence was sufficient to allow for coverage based on diagnosis with type II, III, and IV home sleep testing monitors in appropriately selected patients. ■

Survey Shows Wide Support for Individual Insurance Mandate

BY MARY ELLEN SCHNEIDER
New York Bureau

Most Americans favor a continuation of the employer-based health insurance system and say that they believe health insurance costs should be shared among individuals, employers, and the government, according to the results of a survey conducted by the Commonwealth Fund.

More than two-thirds of Americans who took part would favor a mandate for individuals to obtain health insurance in an effort to provide universal health coverage.

These findings indicate that on certain health reform issues Americans' views may be more closely aligned with the proposals put forth by Democratic candidates for president than those outlined by Republicans.

For example, the leading Democratic candidates would require employers to offer health coverage to employees or pay for part of their coverage, while most of the Republican candidates are proposing changes to the tax code that could potentially reduce the role of employers in the health insurance market, according to a Commonwealth Fund analysis.

Sen. Hillary Clinton (D-N.Y.) and former Sen. John Edwards (D-N.C.) would support an individual insurance mandate, while Sen. Barack Obama (D-Ill.) would mandate coverage for all children. Of all the Republican candidates, no one is proposing an individual insurance mandate, according to the Commonwealth Fund.

From June to October 2007, the Commonwealth Fund conducted a telephone survey of 3,501 adults aged 19 years and older as part of its biennial health insurance survey. The group released the results from four health reform queries before they announced the other findings, which are scheduled to be released in March.

The survey respondents expressed broad support for an employer-based system of health insurance coverage. About 81% of respondents said that employers should either provide health insurance or contribute to a fund in order to cover all Americans. Support for this idea among respondents was high regardless of political affiliation, race, gender, age, and income.

The support for an individual insurance mandate to ensure coverage for all was lower; 68% of the respondents said that they strongly or somewhat favor a requirement that all individuals obtain health insurance. About 25% said they strongly or somewhat opposed the idea. About 7% said they didn't know, or refused to answer.

When respondents were asked who should pay for health insurance for all Americans, 66% favored a system in which costs would be shared by individuals, employers, and the government. About 15% said it should be mostly government financed, 8% said it should be paid for mostly by employers, and 6% favored having individuals pick up the tab. Another 5% said they didn't know, or refused to answer.

The survey also indicated that candidates' views on health care reform will be important in determining votes. About 86% of respondents said health care reform is very or somewhat important in determining their vote. ■