Medicare Outpatient Payments to Focus On Imaging and Quality Next Year

BY ALICIA AULT

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Medicare is making good on a promise to reduce what it sees as runaway costs for certain imaging services in its final rule on hospital outpatient payments for 2009.

The Centers for Medicare and Medicaid Services (CMS) also said that it will continue to hold outpatient departments accountable for quality of care by reducing payment when there has been a failure to meet reporting requirements.

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The rule also covers ambulatory surgery centers (ASCs), and contains a separate set of requirements for those facilities.

In July, the CMS had proposed to increase outpatient pay by 3% in 2009; that has been increased to 3.6% in the final rule. Hospitals (and other entities that receive payments under the outpatient system) that do not report on the 11 quality measures required for 2009 will see their payments reduced by 2% in 2010, for an update of 1.6%.

Quality is a big centerpiece of the new rule. The CMS put hospital outpatient departments on notice that, in the near future, it expects to propose the withholding of payment for care related to illnesses or injuries acquired during the outpatient encounter. Hospitals are already being held accountable for acquired conditions on the inpatient side.

The final rule, published in the Nov. 18 Federal Register, applies to 4,000 outpatient departments, according to the CMS. The agency expects to pay $30 billion in 2009 for outpatient services, up from an estimated $28 billion this year.

Imaging services received a special focus. As proposed earlier in the year, the CMS said that it will now make only a single payment for multiple images made in a single outpatient session. The agency created five imaging-payment groups: ultrasound; computed tomography and computed tomographic angiography without contrast; CT and CTA with contrast; magnetic resonance imaging and magnetic resonance angiography without contrast; and MRI and MRA with contrast.

This new scheme may result in underpayment, according to Madeleine Smith, senior vice president of payment and health care delivery policy at the Advanced Medical Technology Association (AdvaMed), a medical device trade group. AdvaMed expressed concern about the policy when it was proposed because it may provide insufficient payments for multiple procedures when contrast is used with every procedure. AdvaMed also objected to the CMS's proposal that outpatient departments report on four imaging-quality measures in 2009. The measures included MRI of the lumbar spine for lower back pain; mammography follow-up rates; certain abdominal CT scans with contrast; and thorax CT with contrast.

The measures were reviewed by the National Quality Forum, but two of the four, certain CT scans and mammography follow-up rates, were rejected, said Ms. Smith in an interview.

Dr. Kim Allan Williams, director of nuclear cardiology at the University of Chicago, said that the imaging-payment groups and efficiency measures will have little to no effect on cardiology.

A bigger worry is the reduction in reimbursement for cardiac CT and for cardiac positron emission tomography in 2009, said Dr. Williams in an interview, adding that these technologies are "being low-balled for good mathematical—but not good clinical—reasons."

Most device-related procedures in cardiology, neurology, and gynecology will receive minimal increases in payment. But some will see fairly large cuts, including implantation of left ventricular pacing leads (45% reduction) and placement of neurostimulator electrodes (49% reduction).

The agency also followed through on its proposal to institute four new payment groups for visits to "Type B" emergency departments (defined as those that are not open around the clock). Type B reimbursement will be lower than reimbursement for full-service emergency departments.

The agency estimates that it will pay almost $4 billion to 5,100 ASCs in 2009. Overall, ASCs will be paid about 59% of what outpatient departments receive for the same surgical procedure, down from 63% in 2008. However, 27 more procedures will be covered in 2009.

Medicare also is updating conditions for coverage that ASCs must meet. Among those: that the ASC must be more transparent about physicians' financial interests, and that appropriate postsurgical care must be ensured. ■

Contracting Dispute Puts RAC Program On Hold

The national roll out of Medicare's Recovery Audit Contractor program is on hold because of protests filed by two contractors who bid unsuccessfully to be part of the program.

The dispute will be reviewed by the Government Accountability Office (GAO) and a decision is expected in early February. In the meantime, officials at the Centers for Medicare and Medicaid Services have imposed an automatic stay on any work by the four regional recovery audit contractors (RACs) recently selected by the agency.

The stay means that the agency has postponed most of its provider outreach efforts. However, the delay is temporary and not expected to result in any substantive changes to the program, according to CMS.

The RAC program is aimed at identifying and correcting improper payments—both over and under—made through the Medicare fee-for-service program. But the program has been unpopular with physicians, who say it adds administrative hassles and puts the burden on physicians to prove that payments they received were correct.

The RAC program was mandated by Congress as part of the Medicare Modernization Act; it began as a 3-year demonstration project in New York, Massachusetts, Florida, South Carolina, and California.

The demonstration project was completed earlier this year and the national roll out of the program was scheduled to be completed by 2010.

—Mary Ellen Schneider

ICD-10 Transition Will Carry Hefty Price Tag for Physicians

BY MARY ELLEN SCHNEIDER

New York Bureau

The federal government's plan to transition from the ICD-9-CM diagnosis and procedure code set to the ICD-10 by 2011 could cost physicians big bucks, according to a cost analysis commissioned by the Medical Group Management Association and other provider groups.

The cost analysis, which was conducted by Nachimson Advisors, puts the total cost of implementation for a typical small practice with three physicians at $83,290. A typical medium practice with 10 providers would end up spending $285,195, and a typical large practice with 100 providers would spend about $2.7 million, according to the estimate. The estimate includes costs associated with education, process analysis, changes to superbills, information technology changes, increased documentation costs, and cash flow disruption.

For example, because of the greatly expanded number of codes, a one-page superbill would no longer be sufficient to capture all the necessary codes and a longer superbill would likely be impractical. Instead, practices may need to consider using automated tools to help with coding, according to the analysis.

In a letter to the Health and Human Services Department, groups including the MGMA, the American Medical Association, and more than 100 other provider organizations and state medical societies urged the agency to provide more time to implement both the ICD-10 coding sets and the X12 Version 5010 technical standard for electronic transactions that is also being required by HHS.

The department should provide at least 36 months to adopt and implement the 5010 standard in order to accommodate testing at all levels. And physicians and other health care providers will need at least another 60 months after the industry has demonstrated readiness with the 5010 standard before adopting ICD-10, the letter said.

"Physicians are deeply concerned that a hasty transition to a new, complex coding system will result in chaos for all involved, especially if the transition is done in tandem with the implementation of HIPAA's new electronic claim standard (5010)," Dr. Joseph M. Heyman, AMA board chair, said in a statement. "Costs, training, and impact of the new rule have been underestimated by HHS, and must be readdressed before going forward."

The move to a National Provider Identifier was one of the simplest changes called for under HIPAA, said Robert Tennant, senior policy adviser at MGMA, and it still took 4 years to complete. The idea that physicians, hospitals, laboratories, and health plans will be able to implement a much more complex transition to ICD-10 in the next 3 years is unrealistic, he said.

"History tells us that time frame simply won't work," he said.

While MGMA supports the move to ICD-10, a rushed transition to the new system could affect patient care and financially squeeze already struggling physicians, Mr. Tennant said. There's no question that even if the time frame for adoption is extended by HHS, physicians will face significant implementation costs, Mr. Tennant said. However, if physicians and the rest of the industry don't have adequate time to prepare, the price tag could be even higher, forcing some physicians to put off needed investments such as the adoption of electronic health records, he said.

The cost estimate is available online at http://nachimsonadvisors.com/products.asp ■

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