Conversion to ICD-10
On August 22, 2008 CMS published a proposed rule on adopting the new ICD-10 code set. As a brief background, a primary reason for moving to ICD-10 is that the ICD-9 system is running out of new codes, which are needed to accommodate advances in medicine and medical technology; ICD-9 has 17,000 codes compared to 155,000 codes in the ICD-10 system. CMS also states that the ICD-10 code-set would better support value-based purchasing and quality initiatives. The costs associated with learning the new codes and updating transaction software and the proposed timeline have been chief concerns of insurance companies and certain physician groups. Please refer to 45 CFR Parts 160 and 162. Comments on this rule are due October 21. [Source: AAMC—September 23, 2008].

New Transaction Standards
On August 22, 2008 CMS published a proposed rule on adopting the new electronic transaction standards for health care and pharmacy claims (this is often referred to as the "5010" rule). Please refer to 45 CFR Part 162. Comments on this rule are due October 21. [Source: AAMC—September 23, 2008].

Utah Medicaid—Notice of Disallowance
On September, 12 CMS notified the Utah Department of Health that they are disallowing approximately $33 million in payments to UUHC. CMS’ position is that the payments do not conform to the Utah State Plan. These payments relate to fiscal years 2007 and 2008. Hospital Administration and Health Sciences Administration are developing strategies for dealing with this issue. We did not budget payments at those same levels in 2009 due to concerns about the rules under the Medicaid moratoria. Therefore, we currently do not have to make adjustments to the 2009 budget based upon the CMS disallowances.

Medicare Improvements for Patients and Providers Act of 2008
MIPPA highlights — In July, Congress overrode the President’s veto and enacted the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), which was effective on the date the law was passed, July 15, 2008. MIPPA is best known for reversing the 10 percent reduction in physician fees that had occurred on July 1, but contains a number of other provisions of interest to hospital providers, physicians, and suppliers.

Coverage for Cardiac or Pulmonary Rehabilitation for COPD Patients — Effective January 1, 2010, Congress has extended Medicare coverage to cardiac rehabilitation and pulmonary rehabilitation programs for patients with a diagnosis of chronic obstructive pulmonary disease (COPD). This coverage will, of course, be subject to certain criteria and limitations.

Medicare Advantage Plans: Phase Out of IME Payments — Presently, Medicare rates for Medicare Advantage plans include payment for the costs of indirect medical education (IME), in addition, hospitals can submit claims to Medicare and be paid directly for IME for Medicare Advantage patients. Thus, Medicare is paying twice for IME for Medicare Advantage patients. The MIPPA eliminates that double IME payment by phasing out the payment to Medicare Advantage plans for IME, but preserves hospital entitlement to being paid directly by Medicare for IME.

Proposed Composite APCs for Multiple Imaging Procedures
For CY 2009, CMS proposes a new payment methodology for imaging procedures that the Agency believes would account for the efficiencies resulting from performing multiple procedures during a single session. CMS is proposing to package multiple imaging procedures into a newly implemented type of APC called a “composite APC.” Composite APCs, first introduced in CY 2008, pay a single rate for several major services that are commonly performed in the same hospital outpatient encounter and that were previously reimbursed separately. For CY 2009, CMS proposes to create the following five imaging composite APCs: [1] APC 8004 (Ultrasound Composite); [2] APC 8005 (CT and CTA without Contrast Composite); [3] APC 8006 (CT and CTA with Contrast Composite); [4] APC 8007 (MRI and MRA without Contrast Composite); and [5] APC 8008 (MRI and MRA with Contrast Composite). CMS would pay for the composite APCs based on the median cost for multiple imaging services provided in a single session. This amount would also include payment for packaged services furnished on the same date of service as the imaging services included in the composite APC.

Never Events & Present on Admission (POA)
The President’s FY 2009 Budget outlines an approach for addressing serious preventable adverse events or “never events”. The proposal would: [1] Prohibit hospitals from billing the Medicare program for “never events” and prohibit Medicare payment for these events; and [2] Require hospitals to report occurrence of these events or receive a reduced annual payment update. In addition, the fiscal year (FY) 2009 inpatient prospective payment system proposed rule contains proposed changes relating to the addition of nine new conditions to the list of conditions that need to be reported if present on admission (POA) which would bring the total number to seventeen. Also, POA indicator information is necessary to identify which conditions were acquired during hospitalization for the HAC payment provision and for broader public health uses of Medicare data. The five indicator reporting options are “Y,” “N,” “W,” “U,” and “1.” Payment will be made for codes “Y” and “W” only. The “Y” option indicates that the condition was present on admission. [Source: FY09 IPPS Proposed Rule].

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