

Medicare 2007 Update



October 2006 Program

Presented by

Amper's Healthcare Services Group



AMPER, POLITZINER & MATTIA
CERTIFIED PUBLIC ACCOUNTANTS
and CONSULTANTS



Overview of Topics

- Medicare Update
 - Hospital and Ambulatory Services
 - Part D Medicare Prescription Drug
 - Compliance Regulations



Medicare 2007 Update

Hospital and Ambulatory Services

2007 Inpatient Hospital PPS Final Rule

- First year of a three year transition for cost weights
 - CMS proposed to base relative weights on hospital specific costs
- Operating and Capital Payments to all hospitals will increase by \$3.4 billion
- Payment rates will increase by an average of 3.5% to all hospitals
- Only 2% of hospitals have a projected reduction in payment
 - Certain wage indices account for these reductions



Medicare 2007 Update

Hospital and Ambulatory Services

2007 Inpatient Hospital PPS Final Rule

- Goals of Final Rule
 - Meaningful first steps in DRG reform
 - Taking steps toward more accurate payments without disrupting hospital payments
 - Ensuring Medicare does not overpay for some services while underpaying for more severely ill patients
 - Correcting inappropriate hospital incentives for treating certain types of patients by redirecting portions of overpayments to underpaid cases



Medicare 2007 Update

Hospital and Ambulatory Services

2007 Inpatient Hospital PPS Final Rule

- Key Policies for 2007
 - Meaningful refinements to the current CMS classification system
 - Conduct an evaluation w/ public comments of alternative severity adjustment systems for implementation in 2008



Medicare 2007 Update

Hospital and Ambulatory Services

2007 Inpatient Hospital PPS Final Rule

- 2007 Final Rule Impact
 - Limited hospital payment impact due to simultaneous implementation of incremental reforms
 - Payments will better reflect payment accuracy
 - Payments will reflect costs rather than charges
 - Reforms will eliminate bias in the current system
 - Limited hospital payment impact due to simultaneous implementation of incremental reforms



Medicare 2007 Update

Hospital and Ambulatory Services

2007 Inpatient Hospital PPS Final Rule

- 2007 Final Rule Impact on DRG
 - No DRG weight will decrease more than 5.4% in 2007
 - 19 DRG weights increase by more than 5% as compared to the current weight methodology in the 1st year



Medicare 2007 Update

Hospital and Ambulatory Services

2007 Inpatient Hospital PPS Final Rule

- 2007 Final Rule IPPS Changes
 - Changes will help assure all beneficiaries have access to appropriate, high-quality care
 - The Medicare Payment Advisory Commission (MedPAC) supports these reforms
 - Types of payment changes being implemented were described as “promising” in a recently released Government Accountability Office (GAO) report



Medicare 2007 Update

Hospital and Ambulatory Services

2007 Inpatient Hospital PPS Final Rule

- Payments based on costs
 - CMS proposed to base relative weights on hospital-specific costs
 - Hospitals markup charges over costs bearing little relation to costs
 - CMS to refine cost-based method based on public comments



Medicare 2007 Update

Hospital and Ambulatory Services

2007 Inpatient Hospital PPS Final Rule

- 2007 Final Rule Impact on Severity Illness
 - Refinements to prevent underpayments
 - CMS identified 20 new DRG's to improve illness recognition
 - 32 current DRG's modified to better capture differences in severity
 - CMS to conduct evaluation of alternative DRG severity systems



Medicare 2007 Update

Hospital and Ambulatory Services

2007 Inpatient Hospital PPS Final Rule

- Specialty Hospitals
 - Proposed revisions to reduce incentives for hospitals to cross-subsidize
 - Example: Cardiovascular DRG'S



Medicare 2007 Update

Hospital and Ambulatory Services

- Proposed 2007 Medicare Physician Fee Schedule
 - 5.1% decrease in payment rates
 - Proposed changes to components of physician payments:
 - Work component relative value units (RVUs);
 - Changes for calculating practice expenses
- Separate proposed rule for other changes in physician payment policy affecting reimbursement



Medicare 2007 Update

Hospital and Ambulatory Services

- 2007 Proposed Work RVUs
 - Payments for E/M services increase 37%
 - Work Component RVUs for an office visit requiring moderately complex decision making increase by 29%
 - Payments for hospital visits requiring moderately complex decision making increase by 31%
 - Expenditure increase by ~\$4.0 billion
 - CMS proposes 10% budget neutrality adjuster to be applied to work RVUs for Medicare to offset expenditure increase



Medicare 2007 Update

Hospital and Ambulatory Services

- Proposed Practice Expense Changes
 - “Bottom Up” method for direct costs
 - Use of survey data
 - Elimination of the non-physician work pool
 - New method for calculating indirect practice expenses
- 4 year transition to new PE-RVU method
 - 25% phase in each year until 2010



Medicare 2007 Update

Hospital and Ambulatory Services

Other Final Rule Provisions

■ Preventive Services

- Medicare will pay for Abdominal Aortic Aneurysm (AAA) ultrasound screening beginning Jan 1, 2007
- Colorectal Cancer Screening benefit
- Long term steroid therapy and bone mass measurement eligibility



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Hospital and Ambulatory Services

Other Final Rule Provisions

- Imaging Services

- 25% payment decrease for technical component of multiple imaging procedures on contiguous body parts
- Payment caps for multiple imaging procedures



Medicare 2007 Update

Hospital and Ambulatory Services

Other Final Rule Provisions

- Proposed rules on billing Diagnostic Tests
 - Reassignment and physician self-referral rules associated with diagnostic tests
- Composite payment rate for dialysis services provided by ESRD facilities
- Centralized Building/Compliance
 - Self-referral regulation restrictions : space ownership/leasing arrangements that qualify for exceptions



Medicare 2007 Update

Hospital and Ambulatory Services

Other Final Rule Provisions

- Work RVUs assigned to Medical nutrition therapy services:
 - CPT codes 97802, 97803, and 97804
 - HCPCS codes G0270 and G0271



Medicare 2007 Update

Hospital and Ambulatory Services

- Drug reimbursement rates based on manufacturer's average sales price (ASP)
- CMS proposed changes to hospital OPPS
 - Payment rate increases linked to reporting of quality measures
 - Payments decrease 2% for hospitals that fail to report quality measures
 - Estimated 3.0% increase in Medicare payments for outpatient department services in 2007



Medicare 2007 Update

Hospital and Ambulatory Services

- Separate proposed rule for major payment revisions for ambulatory surgical center (ASC) services
 - 14 additional surgical procedures would be added to the list of Medicare approved ASC services
 - Provision of Deficit Reduction Act of 2005 (DRA) caps payment for ASC procedures in 2007 at rate paid to a hospital outpatient department



Medicare 2007 Update

Hospital and Ambulatory Services

- Medically Unbelievable Edits (MUEs) added next year to Medicare Claims processing
 - Unit of Service Limits for more than 10,800 codes billed to Medicare
 - Purpose: Prevent overpayments from the reporting of excess units of service due to errors
 - Appeals process must be used to fight denials based on MUEs



Medicare 2007 Update

Hospital and Ambulatory Services

- MUE and Claims Processing
 - Deputy Director, Program Integrity, Office of Financial Management at CMS indicates it will not be necessary to use a modifier in order to avoid using an MUE
 - Medical Instances exceeding the limit should be appealed
 - CMS appeals process set up for both edits and individual claims



Medicare 2007 Update

Hospital and Ambulatory Services

- CMS will begin using the first phase of 2,828 MUEs in January 2007
 - Edits were sent out to specialty societies for a round of comments through Sept 25, 2006
- Second phase will begin April 2007
 - Comments from Oct 1 – Dec 1, 2006



Medicare 2007 Update

Part D Medicare Prescription Drug

- Initial Open Enrollment Period ending
- 2007 Program
 - **October 1, 2006:** Marketing Plan Activities
 - **November 15 to December 31, 2006:** Annual Coordinated Election Period
 - No enrollment required to renew present coverage
 - **Medicare Part D plan effective January 1, 2007**
 - **January 1 to March 31, 2007:** Special Enrollment Period for beneficiaries enrolled in the Medicare Advantage Plan with Prescription Drug Coverage



Medicare 2007 Update

Part D Medicare Prescription Drug

- Changes in the Standard Medicare Plan:

	<u>2006</u>	<u>2007</u>
Initial Deductible	\$250.00	\$265.00
Initial Coverage Limit	\$2,250.00	\$2,400.00
Out-of-Pocket Threshold	\$3,600.00	\$3,850.00
Minimum Cost-Sharing in the Catastrophic Coverage Portion of the Benefit	\$2 generic/preferred drug (multi-source drug) \$5 all other drugs	\$2.15 generic/preferred drug (multi-source drug) \$5.35 all other drugs
Minimum Co-payments below the Out-of-Pocket Threshold for Certain Low Income Eligible Enrollees	\$2 generic/preferred drug (multi-source drug) \$5 all other drugs	\$2.15 generic/preferred drug (multi-source drug) \$5.35 all other drugs



Medicare 2007 Update

Part D Medicare Prescription Drug

- Part D sponsors
 - The new list of plans that will offer Medicare Part D drug coverage for calendar year 2007 are now available
 - Some plans have already notified CMS that they will not offer coverage next year
 - Insurance providers that opt to continue to participate in Part D have the option to change or raise premiums for their coverage



Medicare 2007 Update

Part D Medicare Prescription Drug

■ Resources:

- AIS: Guide to the Medicare Drug Benefit: <http://www.aishealth.com>
- CMS "Quick Facts About Medicare Prescription Drug Coverage and Protecting Your Personal Information" :
<http://www.medicare.gov/Publications/Pubs/pdf/11147.pdf>
- Medicare questions, verification, plan comparisons, or enrollment: call 800-633-4227 or 1-800-MEDICARE or <http://www.medicare.gov>
- SHIP: Local State Health Insurance Information Program offers free Medicare Part D counseling. Call Medicare at 800-633-4227 or <http://www.shiptalk.org>
- Area Aging Agencies: Contact the local aging agency. Call 800-677-1116



Compliance Update 2007

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Compliance Update 2007

- CMS focus for all providers
- OIG continues to be active
- DOJ prosecuting more criminal cases
- Hospital Compliance Regulations 2005



Compliance Update 2007

- CMS regulations address specialty hospitals
- Medically unlikely edits offer no overrides for denied claims
- HHS announces final rules for e-prescribing and electronic health records
- CMS considers AMA/AHA coding for OPPS facility fees



Compliance Update 2007

- CMS EMTALA policy on ambulance parking at hospitals
- Inappropriate consults risky for hospitals
- OIG favors hospitals that self-disclose possible violations
- Transfer of care redefined



Compliance Update 2007

- Hospitals are starting to embrace the process of risk assessments
- OIG will be watching IT donations by hospitals
- ABN's hospitals should inform patients early in the decision process
- Fraud fighting yields a high ROI



Compliance Update 2007

- Medicaid Integrity Program (MIP) launched
- DOJ inflated MD pay is a Stark violation
- Reporting rules for hospitals grows
- October 1st CMS will only send HIPAA compliant electronic remittances (835)



Compliance Update 2007

- Urgency for Chargemaster accuracy
- St. Barnabas pays \$265 Million as first outlier false claims case
- UMDNJ double billing and fraud could exceed \$243 Million
- OIG going after fraudulent payers and payees as a strategy



Compliance Update 2007

- CMS is working with recovery audit contractors (RAC's)
- Changing the culture at healthcare organizations
- GAO finds Specialty Hospital competition is limited
- OCR HIPAA privacy complaints



Compliance Update 2007

- Physicians continue to pursue joint venture arrangements with hospitals
- Final HIPAA enforcement rule issued
- Compliance oversight still required for cost reports
- Billing errors tied to medical necessity issues



Summary of Topics

- Medicare Update
 - Hospital and Ambulatory Services
 - Part D Medicare Prescription Drug
 - Compliance Developments



Insurance Update 2007

October 2006 Program

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Remember Last Year?

- Predicted increased audits by insurers/gov't
- Restructuring of market with CDHPs
- Harder bargaining positions as insurers consolidate
- New insurance regs

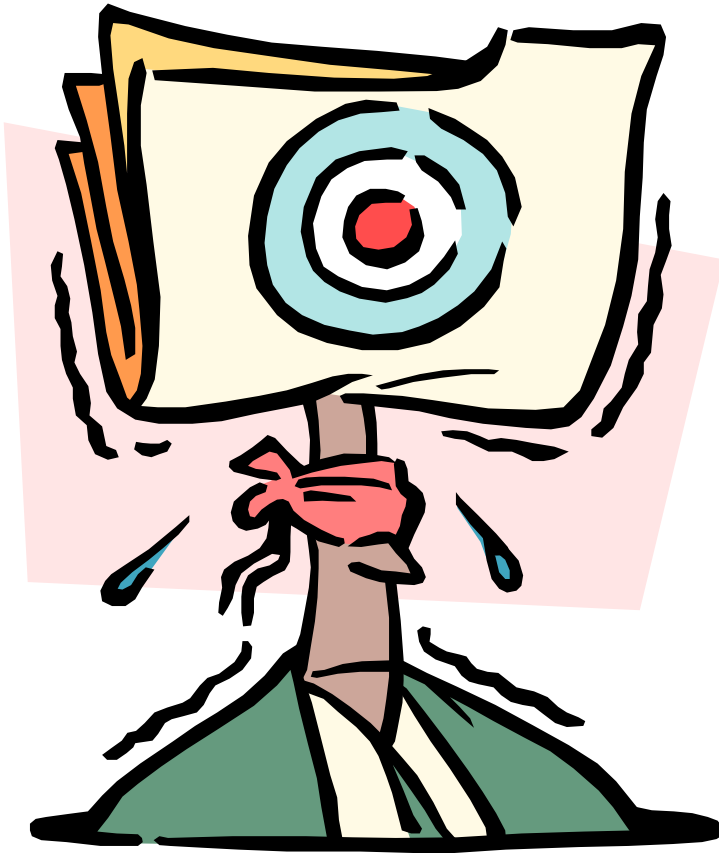




It Happened!

- OIG has released the Medi-Medi Program
- DRA requires states to evaluate false claims
- DSH audits are hammering states
- Outlier actions against hospitals are up
- Premium pressures are increasing CDHPs
- NJ passes the HCAPPA
- NAIC passes SOX for insurers

Medi-Medi Program



- Created by DRA
- Similar to the MIP
- Detect & prevent Medicaid fraud
- CMSO to design fraud and abuse programs
- MIP Contractors will be used in conjunction with gov't workers



Medi-Medi Program Design

■ Principles

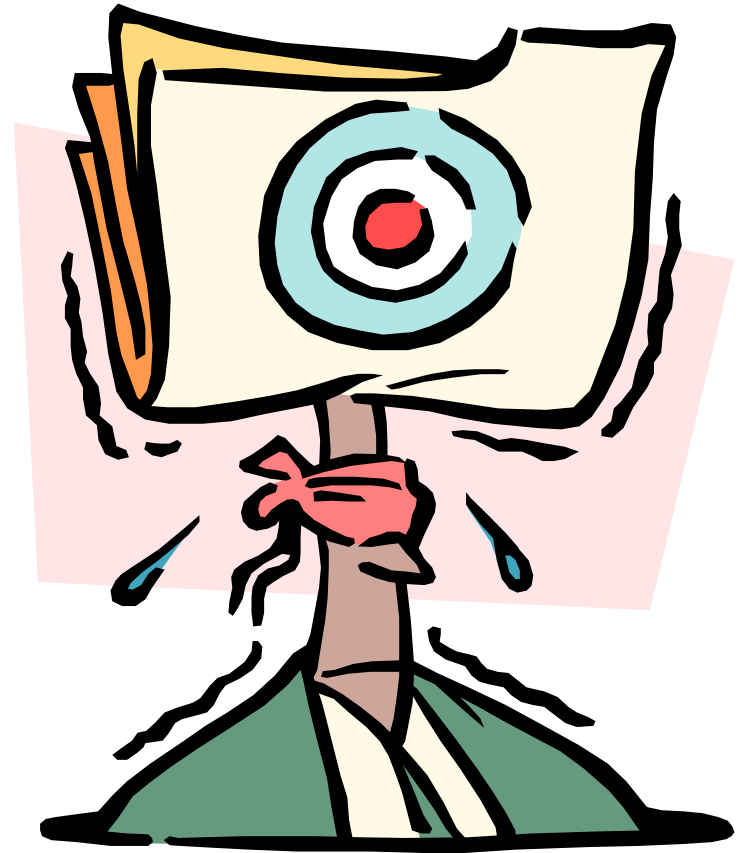
- Nat'l Leadership
- Accountability
- Collaboration
- Flexibility

■ Functions

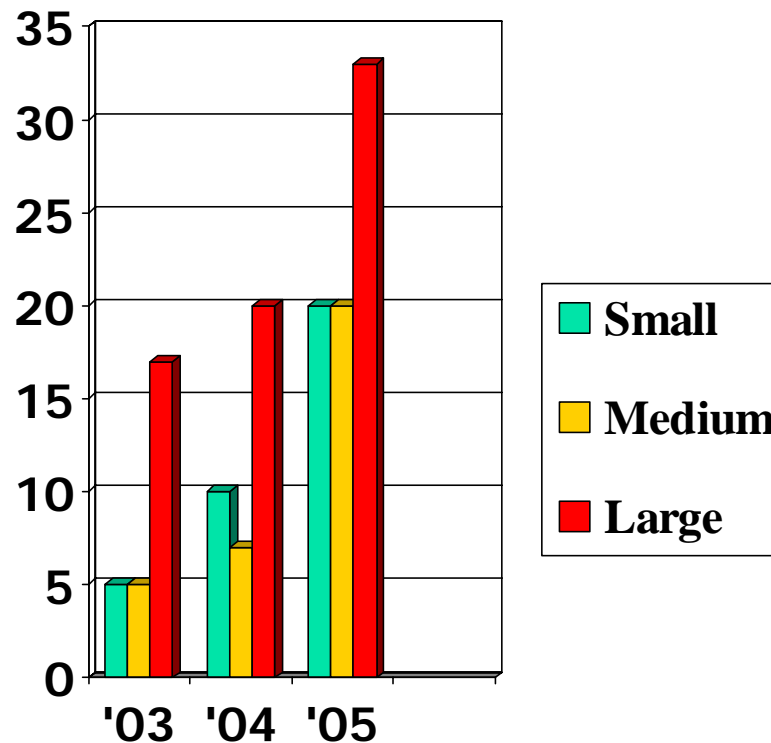
- Create CMIP
- Procure/oversee MICs
- Field Operations
- Fraud Research and Detection
- Congressional 4/07, funding to increase 12M/yr thru 2010

DRA Bonus to States

- States encouraged to pass false claims acts similar to OIG
- 10% bonus collection
- Law must contain:
 - Whistleblower
 - 60 day AG review
 - Treble damages



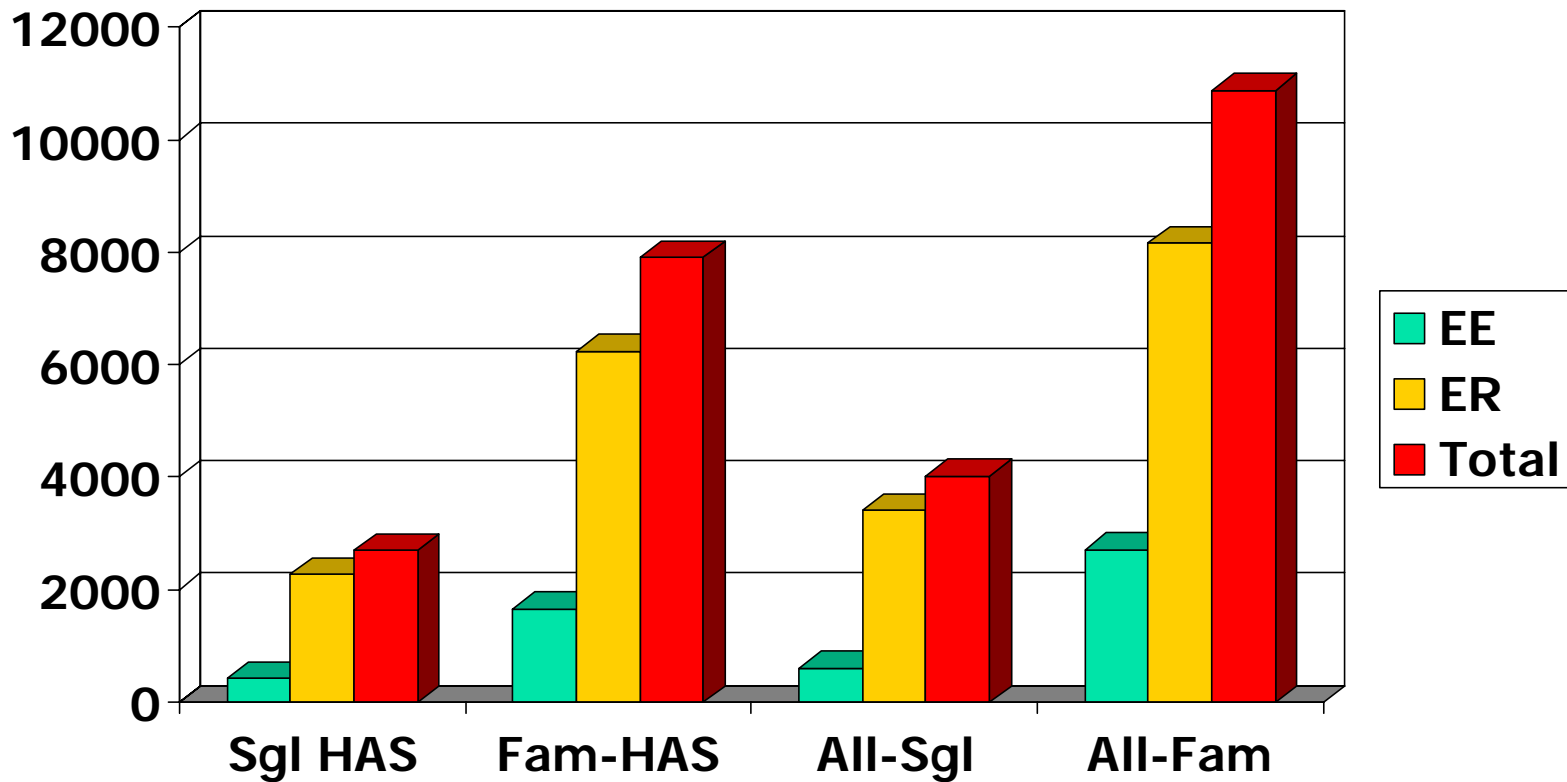
CDHP's Gaining Momentum



- Employer costs up
- Trends show no signs of breaking
- Pressure to keep competitive
 - Industry
 - Talent Pool

Average Annual Premiums and Contributions to Spending Accounts For Singles/ Families Covered in HSA Qualified HDHPs Compared to All Plans, 2005

(Source HRET 2005 Study)





Insurers Driving Hard Bargains

- United Healthcare taking tough positions in market place
- Medicaid and Medicare spending will be below healthcare inflation rates
- Pay for performance is showing up in more contracts, paradigm shift?



Washington Insurance Updates

- MSA's and MH Parity extended (HR 5970)
 - MSAs will expire in 12/07
 - Mental Health Parity Act extended thru 12/07 for GHP's >50
- Tax Reform? (Breaux)
 - Proposed limit to employer HP deductions
 - 06 \$5000 single, \$11,500 family
 - "Save for Family Accounts"
- State-Based HC Reform (Feingold S 3776)
 - \$32B over 10 years
 - Help states implement "Universal Healthcare"
 - Benefits similar to FEHBP

Health Claims Authorization Processing and Payment Act



- Enacted 1/12/06, effective 7/11/06
- Many providers unaware or not prepared to implement
- Amends HCQA with respect to IHCAP Program



Health Claims Authorization Processing and Payment Act

- Covered person (CP) may now give consent prior to service
- Consent valid through all levels of appeals
- Provider must notify CP in writing at each stage of the appeal
- CP may revoke consent at any time by writing the provider
- Valid only for DOS 7/11/06 and beyond
- Forms are available, see Bulletin 06-16



Health Claims Authorization Processing and Payment Act

- 90 statutory timeframe for filing appeal continues to apply
- If a provider disagrees with a final appeal decision, they can apply for arbitration
- Establishes an Arbitration Organization “AO” to hear single or multiple claim issues
- Statute of Limitations does not apply until AO contract is awarded

Coding and Documentation 2007 Update



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Overview of Topics

- 2007 Diagnosis Code Changes
- 2007 CPT Code Changes
- Abdominal Aortic Aneurysm (AAA) Screening
- 2007 DRG Changes
- 2007 OPPS Changes
- Ambulatory Surgery Centers
- National Provider Identifiers (NPI)
- Office of Inspector General (OIG) Work Plan



2007 Diagnosis Code Changes

New/Revised ICD-9 Codes Effective October 1, 2006

- Codes are effective 10/1/06 with no grace period
 - 211 New Diagnosis Codes
 - 55 Revised Codes
 - 29 Deleted (invalid) Diagnosis Codes



2007 Diagnosis Code Changes

- **Infectious & Parasitic Diseases** – 3 New Codes
 - 052.2 Postvaricella Myelitis
 - 053.14 Herpes Zoster Myelitis
 - 054.74 Herpes Simplex Myelitis
- **Neoplasms - Hematologic Malignancies** – 7 New Codes
 - Essential thrombocytopenia
 - Myelodysplastic Syndrome Codes
 - Myelofibrosis
- **Endocrine, Nutritional and Metabolic, Immunity** – 3 New Codes
 - Amyloidosis
 - Familial Mediterranean Fever
 - Other Amyloidosis



2007 Diagnosis Code Changes

- **Blood and Blood Forming Organs** – 23 New Codes
 - Aplastic anemia and white blood cell disorders expanded (284.01, 284.09, 284.1, 284.2, 288.00 – 288.69)
 - Neutropenic splenomegaly and Myelofibrosis (289.53, 289.53)
- **Nervous System & Sense Organs** – 40 New Codes
 - Separate Codes for Encephalitis/Encephalomyelitis and Myelitis (323.01-323.82)
 - Mild cognitive impairment, so stated (331.83)
 - Athetoid cerebral palsy (333.71)
 - Acute dystonia due to drugs (333.72)
 - Other acquired torsion dystonia (333.79)
 - Subacute dyskinesia due to drugs (333.85)
 - Restless Legs syndrome (333.94)
 - Pain syndromes (338.0-338.4)



2007 Diagnosis Code Changes

- **Nervous System & Sense Organs (cont)**
 - Myelitis (341.20 – 341.22)
 - Optic nerve hypoplasia (377.43)
 - Inflammation of postprocedural bleb (379.60 – 379.63)
 - Sensorineural hearing loss unilateral and asymmetrical (389.15 – 389.16)
- **Circulatory System – 1 New Code**
 - Takotsubo Syndrome (429.83)
- **Respiratory System - 5 New Codes**
 - Nasal mucositis (478.11)
 - Other diseases of nasal cavity (478.19)
 - TRALI (Transfusion related acute lung injury) – 518.7
 - Acute bronchospasm *without Asthma DX-* (519.11)
 - Other diseases of the trachea and bronchus



2007 Diagnosis Code Changes

- **Digestive System** – 31 New Codes
 - Cracked tooth (521.81)
 - Other specific diseases of hard tissues of the teeth (521.89)
 - Acute and Chronic gingivitis (523.00 – 523.11)
 - Aggressive, Acute and Chronic periodontitis (523.30 – 523.42)
 - Dental restorations – repairs, fractures, and complications (525.60 – 525.69)
 - Perforation of root canal space (526.61)
 - Endodontic over fill and under fill (526.62 – 526.63)
 - Other periradicular pathology (526.69)
 - Stomatitis and Mucositis (528.00 – 528.09)
 - Gastrointestinal Mucositis (538)



2007 Diagnosis Code Changes

- **Genitourinary System** – 11 New Codes
 - Torsion of testis and spermatic cord (608.20 – 608.24)
 - Mucositis cervix, vagina and vulva (616.81)
 - Other inflammatory disease of cervix, vagina, and vulva (616.89)
 - Cervical stump prolapse (618.84)
 - Other female mutilation status (629.29)
 - Other specified disorders of female genital organs (629.89)
- **Complications of Pregnancy, Childbirth and Puerperium** – 33 New Codes
 - Tobacco Use Complicating (649.00 – 649.04)
 - Obesity Complicating (649.10 – 649.14)
 - Bariatric Surgery Status Complicating (649.20 – 649.34)
 - Coagulation Disorders Complicating (649.30 – 649.34)
 - Epilepsy Complicating (649.40 – 649.44)
 - Spotting Complicating (649.50 – 649.53)
 - Uterine size discrepancy (649.60 – 649.64)



2007 Diagnosis Code Changes

- **Musculoskeletal System and Connective Tissue – 5 New Codes**
 - Nontraumatic compartment syndrome (729.71 – 729.79)
 - Major Osseous Defects (731.3)
- **Conditions in the Perinatal Period – 6 New Codes**
 - Hypoxic-ischemic encephalopathy HIE (768.7)
 - Respiratory Arrest of newborn (770.87)
 - Hypoxemia of newborn (770.88)
 - Other acidosis of newborn (775.81)
 - Other neonatal endocrine and metabolic disturbances (775.89)
 - Cardiac Arrest of newborn (779.85)



2007 Diagnosis Code Changes

- **Symptoms, Signs, and Ill-Defined Conditions**
 - 13 New Codes
 - Complex febrile convulsions (780.32)
 - Generalized pain (780.96)
 - Altered mental status (780.97)
 - Postnasal drip (784.91)
 - Other symptoms involving head and neck (784.99)
 - Urinary hesitancy (788.64)
 - Straining on urination (788.65)
 - Image test inconclusive due to body fat (793.91)
 - Other nonspecific abnormal findings on radiological and other examinations of body structure
 - Pap smear of cervix cytologic with evidence of malignancy



2007 Diagnosis Code Changes

- **Symptoms, Signs, and Ill-Defined Conditions (cont)**
 - Elevated carcinoembryonic antigen –CEA (795.81)
 - Elevated cancer antigen 125 – CA 125 (795.82)
 - Other abnormal tumor markers (795.89)



2007 Diagnosis Code Changes

- **Injury and Poisoning – 11 New Codes**
 - Compartment syndrome (958.90 – 958.99)
 - Unspecified adverse effect of unspecified drug, medicinal and biological substance (995.20)
 - Arthus phenomenon (995.21)
 - Unspecified adverse effect of anesthesia (995.22)
 - Unspecified adverse effect of insulin (995.23)
 - Unspecified adverse effect of other drug, medicinal and biological substance (995.29)



2007 Diagnosis Code Changes

- V Codes– 19 New Codes
 - Family history of colon polyps (V18.51)
 - Family history of other digestive disorders (V18.59)
 - Testing of male for genetic disease carrier status (V28.34)
 - Encounter for testing of male partner of habitual aborter (V26.35)
 - Other genetic testing of male (V28.39)
 - Bariatric surgery status (V45.86)
 - Encounter for change or removal of non-surgical dressing (V58.30)
 - Encounter for change of surgical dressing (V58.31)
 - Encounter for removal of sutures (V58.32)



2007 Diagnosis Code Changes

- V Codes (cont)
 - Encounter for hearing examination following failed hearing screening (V72.11)
 - Other examination of ears and hearing (V72.19)
 - Screening for genetic disease carrier status (V82.71)
 - Other genetic screening (V82.79)
 - Body mass index (V85.51 – V85.54)
 - Estrogen receptor positive status- ER+ (V86.0)
 - Estrogen receptor negative status- ER- (V86.1)



2007 CPT CODE CHANGES

CPT Changes

- 199 New Codes
- 76 Revised Codes
- 105 Deleted Codes

Codes Effective 1/1/07 with no grace period



2007 CPT CODE CHANGES

- Anesthesia – 2 New Codes; 1 Deleted Code
- Integumentary – 21 New Codes; 16 Deleted Codes
 - Surgical prep or creation of recipient site by excision of open wounds, burn or scar (including subcutaneous tissues), or incisional release of scar contracture
 - 4 Codes – Based on site and size
 - Moh's Micrographic Technique
 - 5 New Codes (17311 – 17315)
 - 5 Deleted Codes (17304 – 17307 and 17310)
 - Mastectomy
 - 8 New Codes (19300 – 19307)
 - 8 Deleted Codes (19140, 19160, 19162, 19180, 1982, 19200, 19220 & 19240)



2007 CPT CODE CHANGES

- CPT Code Changes for 2007
 - Musculoskeletal – 13 New Codes; 7 Deleted Codes
 - Percutaneous intradiscal electrothermal annuloplasty
 - Total disc arthroplasty; Revision; Removal
 - Excision of tendon, forearm and/or wrist
 - Percutaneous skeletal fixation of distal radial fracture (fx)
 - New Codes: 25606 Deleted Code: 25611
 - Open treatment of distal radial fx
 - New Codes: 25607 – 25609
 - Deleted Code: 25620
 - Neurectomy
 - New Codes: 27325, 27326 & 28055
 - Deleted Codes: 27315, 27320 & 28030



2007 CPT CODE CHANGES

- Respiratory – 1 New Code; 3 Deleted Codes
- Cardiovascular – 26 New Codes; 10 Deleted Codes
 - Insertion of epicardial electrode(s)
 - Operative tissue ablation & reconstruction of atria
 - Endoscopy, surgical; operative tissue ablation & reconstruction of atria
 - Closure of multiple ventricular septal defects
 - Repair of pulmonary venous stenosis



2007 CPT CODE CHANGES

- Cardiovascular, continued
 - Thromboendarectomy
 - 5 New Codes: 35302- 35306
 - Deleted Code: 35381
 - Bypass Graft
 - 6 New Codes: 35537 –35540; 35637 – 35638
 - 4 Deleted Codes: 35507; 35541; 35546 & 35641
 - Uterine fibroid embolization
 - New Code: 37210



2007 CPT CODE CHANGES

- Digestive – 15 New Codes; 6 Deleted Codes
 - Neurostimulator Electrodes
 - Laparoscopy; Implantation; Revision; Removal
 - Colectomy, total, abdominal, with proctectomy
 - New Codes: 44157 & 44158
 - Deleted: Colectomy, total, abdominal without proctectomy – 44152 & 44153
 - Anastomosis, choledochal cyst, without excision
 - New Code: 47719
 - Deleted Code: 47716
 - Resection or debridement of pancreas & peripancreatic tissue for acute necrotizing pancreatitis
 - New Code: 48105 Deleted Code: 48005
 - Pancreaticojejunostomy
 - New Code: 48548 Deleted Code: 48180



2007 CPT CODE CHANGES

- Digestive, continued
 - Removal of peritoneal foreign body from peritoneal cavity
 - New Code: 49402 Deleted Code: 49085
- Male Genital System – 3 New Codes; 3 Deleted Codes
- Female Genital System – 10 New codes; 1 Deleted Code
 - Hymenotomy, Simple incision
 - New Code: 56442 Deleted Code: 56720
 - D & C of Cervical Stump
 - New Code: 57558 Deleted Code: 57820
 - Laparoscopy, surgical, supracervical hysterectomy
 - New Codes: 58541 – 58544
 - Laparoscopy, surgical with radical hysterectomy - 58548



2007 CPT CODE CHANGES

- Nervous System – 2 New Codes
- Eye & Ocular – 1 New Code; 1 Deleted Code
 - Biopsy of extraocular muscle
 - New Code: 67346 Deleted Code: 67350
- Radiology – 46 New Codes; 41 Deleted Codes
 - MRI of brain – 70554 & 70555
 - Ultrasound, pregnant uterus – 76813 & 76814
 - Ultrasonic guidance, intraoperative – 76998
 - CT guidance for stereotactic localization - 77011



2007 CPT CODE CHANGES

- Radiology – 46 New Codes; 41 Deleted Codes
 - CT guidance for needle placement – 77021 (Deleted: 76360)
 - Stereotactic localization guidance for breast biopsy or needle placement – 77031 (Deleted: 76095)
 - Mammography; unilateral – 77055 (Deleted: 76090)
 - Mammography; bilateral – 77056 (Deleted: 76091)
 - Screening Mammography; bilateral – 77057 (Deleted: 76092)



2007 CPT CODE CHANGES

- Radiology – 46 New Codes; 41 Deleted Codes
 - Bone Density Studies
 - Dual-energy x-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg. Hips, pelvis, spine)
 - New Code: 77080 Deleted Code: 76075
 - DXA, bone density study, 1 or more sites; appendicular skeleton (eg. Radius, wrist, heel)
 - New Code: 77081 Deleted Code: 76076
 - DXA, bone density study, 1 or more sites; vertebral fracture assessment
 - New Code: 77082 Deleted Code: 76077



2007 CPT CODE CHANGES

- Pathology/Lab – 11 New Codes
- Medicine – 20 New Codes; 5 Deleted
 - Ventilation Assist and Management
 - Initial Day, Hospital –
 - New: 94002 Deleted: 94656
 - Subsequent Day, Hospital
 - New: 94003 Deleted: 94657
 - Nursing Facility, Per Day – New Code: 94004
 - Home Ventilator Management Care Plan Oversight of a Patient – New Code: 94005



2007 CPT CODE CHANGES

- Medicine, continued
 - Continuous inhalation treatment with aerosol medication for acute airway obstruction
 - First Hour – 94644
 - Each Additional Hour 94645
 - Pediatric Home Apnea Monitoring Event Recording
 - Codes 94774 – 94777
 - Medical Genetics & Genetic Counseling Services, each 30 minutes face-to-face with patient/family –
 - Code 96040



2007 CPT CODE CHANGES

- Category II Codes – 1 Deleted Code
 - 2003F – Auscultation of the heart performed
- Category III Codes – 16 New Codes; 9 Deleted Codes



Abdominal Aortic Aneurysm (AAA) Screenings

Welcome to Medicare Exam New Service

- Abdominal Aortic Aneurysm (AAA) Screenings
 - Must be referred as a result of the Welcome to Medicare Exam
 - Medicare has never paid for a screening for the patient
 - Patient has any of the following risk factors
 - Family history of AAA
 - Male between 65 & 75 who has smoked at least 100 cigarettes in his life
 - Any other subsequent criteria recommended by the US Preventive Services Task Force



Abdominal Aortic Aneurysm (AAA) Screenings

- CMS proposes creating a new G code with the description:
 - Ultrasound, B-scan and/or real time with image documentation; for AAA screening
- Will be reimbursed the same amount as for the CPT code used for diagnostic tests – 76775
 - 2006 Reimbursement - \$87.16



Abdominal Aortic Aneurysm (AAA) Screenings

- The task force specifically recommends that women are not routinely screened for AAA
 - “Important harms, including an increased number of surgeries with associated morbidity and mortality, and psychological harms outweigh the benefits”



2007 DRG CHANGES

- 20 New DRGs
- 32 Modifications
- 8 Deletions



2007 DRG CHANGES

- Payment will be based on costs instead of charges. (33/67)
 - Medical DRG weights will increase by 7.3%
 - Surgical DRG weights will decrease by 6.9%
- CMS adopting severity DRGs FY 2008
- CMS revised the CC list (Complications and Co-Morbidities)



2007 DRG CHANGES

Top 10 Increased DRG's

- 375- Vaginal Delivery with OR Procedure
Except Sterilization &/or D&C
- 417- Septicemia Age 0-17
- 431- Childhood Mental Disorders
- 522- Alcohol/Drug Abuse or Dependence
with Rehabilitation Therapy without CC
- 61- Myringotomy with Tube Insertion Age >17



2007 DRG CHANGES

433- Alcohol/Drug Abuse or Dependence, Left
AMA

76- Postpartum & Post Abortion Diagnoses
without OR Procedure

384- Other Antepartum Diagnoses without
Medical Complications

381- Abortion with D&C, Aspiration Curettage or
Hysterotomy

512- Simultaneous Pancreas/Kidney Transplant



2007 DRG CHANGES

Top 10 Decreased DRG's

26- Seizure & Headache Age 0-17

52- Cleft Lip and Palate Repair

70 – Otitis Media and URI Age 0-17

91- Simple Pneumonia & Pleurisy Age 0-17

212- Hip & Femur Procedures Except Major Age 0-17



2007 DRG CHANGES

291- Thyroglossal Procedures

327- Kidney & Urinary Tract Signs and
Symptoms Age 0-17

377- Postpartum & Post Abortion
Diagnoses with OR Procedure

396- Red Blood Cell Disorders Age 0-17

513- Pancreas Transplant



2007 OPPTS CHANGES

E/M Codes

- Hospital Outpatient Setting
 - CMS states the current model of physician-based CPT codes is not appropriate for use in the hospital setting
 - 17 New HCPCS “G” Codes
 - Five to report hospital clinic visits
 - Five to report emergency department (ED) visits provided by a hospital outpatient ED that meets the definition of an ED (open 24 hours, seven days per week)
 - Five to report ED visits by a dedicated (DED) defined as not always open after hours but still meeting EMTALA and other criteria
 - Two to report critical care



2007 OPPS CHANGES

E/M APC Payment Levels

- Maximum payment for clinic visits would increase from \$92 to \$133
- ED visits would increase from a current maximum of \$244 to \$345



2007 OPPTS CHANGES

Drug Administration

- CMS will now pay separately for the initial infusion codes as well as additional hours add-on codes for both chemotherapy and non-chemotherapy services
- There will be the addition of six new drug administration APC's



2007 OPPTS CHANGES

- Packaged Drugs
 - The median cost of less than \$50 considered packaged will be increased to less than \$55
- Separately Payable Drug Reimbursement
 - Decrease from the current model of average sales price (ASP) +6% down to ASP +5%
- Packaged Services
 - Six “Special Package” Codes
 - Separate APC payment for these services when reported on a date of service with no other separately payable OPPTS service



2007 OPPTS CHANGES

- Packaged Services, continued
 - CPT Codes
 - 36540 – Collection of blood specimen from a completely implantable venous access device
 - 36600 – Arterial puncture, withdrawal of blood for diagnosis
 - 38792 – Injection procedure; lymphangiography for identification of sentinel node
 - 75893 – Venous sampling with or without angiography, radiological supervision and interpretation
 - 94762 – Noninvasive ear or pulse oximetry of O₂ saturation by continuous overnight monitoring
 - 96523 – Irrigation of implanted venous access device for drug delivery systems



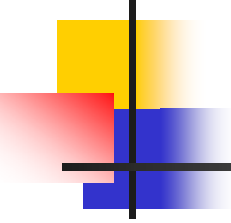
Ambulatory Surgery Centers (ASC's)

- The proposed 2007 OPPS rule would add 14 surgical procedures to the list for Medicare reimbursement ASC's in 2007
- Codes, Description, ASC Payment Group
 - 13102 Repair wound/lesion add-on (1)
 - 13122 Repair wound/lesion add-on (1)
 - 13133 Repair wound/lesion add-on (1)
 - 19297 Place breast cath for radiation (9)
 - 21356 Treat cheek bone fracture (3)
 - 22520 Percutaneous vertebroplasty,
thoracic (9)



Ambulatory Surgery Centers (ASC's)

- Codes, Description, ASC Payment Group
 - 22521 Percutaneous vertebroplasty
lumbar (9)
 - 22522 Percutaneous vertebroplasty,
additional (1)
 - 35476 Repair venous blockage (9)
 - 36818 AV fuse, upper arm, cephalic (3)
 - 37205 Transcath IV stent, percutaneous (9)
 - 37206 Transcath IV stent/perc, add'l (1)
 - 43761 Reposition gastrostomy tube (1)
 - 46946 Ligation of hemorrhoids (1)



National Provider Identifiers (NPI)

- HIPAA covered entities such as providers completing electronic transactions, healthcare clearinghouses, and large health plans, must use only the NPI to identify covered healthcare providers in standard transactions by May 23, 2007
- How to apply:
 - Web applications: <https://nppes.cms.hhs.gov>
 - Download applications & mail to: NPI Enumerator, PO Box 6059, Fargo, ND 58108-6059
 - Phone Contact: 800-465-3203



Office of Inspector General (OIG) Physician Work Plan

Physician OIG Work Plan for 2007

- Wound Care
 - Review whether claims for wound care services were medically necessary & will examine the controls preventing improper payments for these services
- “Incident-to” Services
 - Appropriateness of Medicare services performed “incident-to” the professional services of physicians & will determine whether the services met the standards for medical necessity, documentation & quality of care



Office of Inspector General (OIG) Work Plan

- Medicare's Assignment Rules
 - Review whether patients are being billed more than the Medicare allowable for services. OIG will examine whether patients are aware of their rights should they be overcharged
- Use of Imaging Services in Physician Offices
 - Growth of imaging services in physician offices
 - Billing patterns in geographic regions & practice settings



Office of Inspector General (OIG) Work Plan

- Polysomnography Tests (Sleep Studies)
 - Review whether sleep studies are billed appropriately to Medicare
 - 2001 Medicare Payments - \$62 Million
 - 2004 Medicare Payments -\$170 Million
- Pathology Services in Physician Offices
 - More than \$1 billion in annual Medicare payments
 - Relationships between physicians who provide services in their offices & outside pathology companies



Office of Inspector General (OIG) Work Plan

- Eye Surgery
 - Review whether cataract and laser eye surgeries are being billed correctly
- Billing Services
 - How relationships between medical practices and billing companies may affect your billing



Office of Inspector General (OIG) Work Plan

- **Cardiography/Echocardiography**
 - Review whether practices correctly bill for the technical & professional components
- **Welcome to Medicare Exam Payment**
 - Review whether Initial Preventive Physical Exam (IPPE) payments for existing practice patients who are new to Medicare are a wise expenditure of Medicare dollars
 - IPPE pays a higher payment for work that could have been done on a previous E/M visit



Office of Inspector General (OIG) Work Plan

- PT/OT Services
 - To determine if services were medically necessary, documented correctly & certified by physicians
- Botox Treatments
 - Check for billing abuse
 - Medicare pays for certain spastic conditions but not to erase wrinkles



Office of Inspector General (OIG) Hospital Work Plan

Hospital OIG Work Plan for 2007

- Inpatient Rehabilitation Facility (IRF) Classification Criteria
 - Review of the extent of admissions to IRF's & whether they meet specific regulations & whether the facilities billed for services in compliance with Medicare rules



Office of Inspector General (OIG) Work Plan

- Medical Appropriateness & Coding of DRG Services
 - To identify providers who exhibit high or unusual patterns for certain DRGs by reviewing inpatient hospital claims. The reviews will determine medical necessity, appropriate level of coding and reimbursement for a sample of services billed by the providers.



Office of Inspector General (OIG) Work Plan

- IRF Compliance with Medicare Requirements
 - Review of payments to IRF's under the prospective payment system & whether they were made in accordance with Medicare rules, including whether a claim paid as a discharge should have been paid as a transfer, and outlier claims.



Office of Inspector General (OIG) Work Plan

- Oversight of Specialty Hospitals
 - Review CMS's oversight of physician-owned specialty hospitals to ensure patient safety and quality of care. The review will include examination of policies on staffing requirements



Office of Inspector General (OIG) Work Plan

- “Inpatient Only” Services Performed in an Outpatient Setting
 - Determine if Medicare payments are appropriately denied for “inpatient only & related services performed in an outpatient setting and assess the extent to which Medicare beneficiaries are held liable for denied inpatient claims for these services.



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