

Final 2012 Hospital Outpatient Prospective Payment System Rule

APC Assignments and Associated Reimbursement for Cardiac Computed Tomography Services

The final 2012 Hospital Outpatient Prospective Payment System rule was released November 1, 2011. The Centers for Medicare and Medicaid Services (CMS) has rejected SCCT's request to re-evaluate the claims data CMS used to establish the payment rate for cardiac computed tomography services in Calendar Year (CY) 2012. It is CMS' assertion that the Agency is using appropriate claims submitted to the Agency by providers, and that it has no reasons to believe that the claims are incorrect.

Therefore, the payment rates for 2012 are as follows:

*75571 - remains assigned to APC 0340; final median cost = \$46 for 2012. Median cost for 2011 was \$46.23.

CMS notes that it believes 75571 is a minor ancillary procedure and thus is appropriately assigned to APC 0340 in terms of resources and clinical similarity to other services.

*75572, 75573 and 75574 –assigned to APC 0383; final median cost = \$262 for 2012. Median cost for 2011 was \$256.86.

SCCT argued that providers are not accounting for all costs associated with the provision of cardiac CT services, and in some cases, are reporting services using the old Category III tracking codes in effect prior to January 1, 2010. In response, CMS strongly suggested that all providers refer to the Provider Reimbursement Manual (Pub 15-2, Part 2, Chapter 40 Hospital and Health Care, Form CMS 2552-10) for CMS instructions on reporting costs. CMS also noted that the appropriateness of all HOPPS payment rates depends on the quality and completeness of the claims data submitted.

As noted in sessions at the SCCT Annual Scientific Meeting, it is very important that all providers use the four Category I codes to report SCCT, and that a thorough and accurate accounting of all costs be captured in order to obtain appropriate reimbursement for cardiac CT services .

New Cost Center for Computed Tomography

CMS noted that it finalized its proposal (under the FY 2011 Hospital Inpatient Prospective Payment System rule) to create new standard cost centers for "Computed Tomography," "Magnetic Resonance Imaging ," and "Cardiac Catheterization," and to require that hospitals report the costs and charges for these services under the new cost centers on the revised Medicare cost report Form CMS 2552-10. CMS noted that its contractor, RTI, found that the costs and charges of CT scans, MRI, and cardiac catheterization differ significantly from the costs and charges of other services included in the standard associated cost center. RTI also concluded that both the hospital inpatient prospective payment system and hospital outpatient prospective payment system relative weights would better estimate the costs of

these services if CMS were to add standard cost centers for CT scans, MRI, and cardiac catheterization. This would allow hospitals to report separately the costs and charges for these services and enable CMS to calculate unique cost-to-charge ratios (CCRs) to estimate the cost from charges on claims data. The new standard cost centers for MRI, CT scans, and cardiac catheterization are effective for cost report periods beginning on or after May 1, 2010, on the revised cost report Form CMS-2552-10.

CMS has noted that they will reassess the availability of data for the “MRI, CT Scans, and Cardiac Catheterization” cost centers, for the CY 2013 OPPS rulemaking cycle. If appropriate, they will propose to create distinct CCRs for these cost centers at that time.

Pass through payments for contrast agents

CMS finalized a proposal to ensure that duplicate payments are not made for contrast agents. When a contrast agent with pass-through status is billed with any procedural Ambulatory Payment Classification, an example of which is APC 0383, a specific offset based on the procedural APC will be applied to payments for the contrast agent to ensure that duplicate payment is not made for the contrast agent.

SCCT plans to send to each member a HOPPS reimbursement Issue Brief and checklist for working with your institution to ensure a thorough and accurate accounting of the true costs associated with performing cardiac CT services. The claims data submitted by each and every hospital that provides cardiac CT services to Medicare beneficiaries helps to determine the payment CMS assigns for cardiac CT services. Without complete and thorough reporting, we cannot expect to receive fair and appropriate reimbursement for the services we provide.