

Analysis of Final Rule for 2010 Revisions to the Medicare Hospital Outpatient Prospective Payment System

The final rule for calendar year (CY) 2010 changes to the Medicare Hospital Outpatient Prospective Payment System (OPPS) and changes to the Ambulatory Surgical Center Payment System was published in the *Federal Register* on November 20, 2009. This rule is effective for services rendered on or after January 1, 2010.

This analysis summarizes key provisions in the CY 2010 OPPS final rule that may be of particular interest to health information management (HIM) professionals.

NOTICE: *This review of the CY2010 OPPS Final Rule is intended as an overview of the rule and not as a complete detailed analysis of the rule. Readers seeking to comply with this rule are encouraged to read the entire Final Rule and not rely on this or any other summary of the rule. In writing this Rule, the Centers for Medicare & Medicaid Services (CMS) presumes that readers are familiar with the notice of proposed rulemaking (NPRM) issued on July 20, 2009.*

The listed page numbers refer to the beginning of the relevant section of the final rule published in the *Federal Register*. The final rule can be accessed at: <http://edocket.access.gpo.gov/2009/pdf/E9-26499.pdf>.

II. Updates Affecting OPPS Payments (74FR60324)

II.A.1.b. Use of Single and Multiple Procedure Claims (74FR60324)

CMS has assigned status indicator “Q2” to CPT code 76098, Radiological examination, surgical specimen. When this service is furnished with a separately payable surgical procedure with status indicator “T” on the same day, payment for CPT code 76098 is packaged. Otherwise, payment for this CPT code is made separately through APC 0317, Level II Miscellaneous Radiology Procedures.

CMS is adopting their proposed methodology to use a bypass list to create “pseudo” single claims. HCPCS codes were added to the CY 2010 bypass list based on whether they met a set of empirical criteria and, if they did not, whether CMS believes the amount of redistributed packaged cost that their inclusion on the bypass list would generate would be appropriate. Table 2 on page 60331 of the final rule contains the final list of bypass codes for CY 2010.

II.A.2.d.1. Device-Dependent APCs (74FR60365)

CMS adopted as final their proposed CY 2010 payment policies for device-dependent APCs. The CY 2010 OPPS payment rates for device-dependent APCs are based on their median costs calculated from CY 2008 claims and the most recent cost report data, using only claims that pass the device edits, do not contain token charge for devices, and do not have a modifier signifying that the device was furnished without cost or with full or

partial credit. The CY 2010 device-dependent APCs are listed in Table 8 on page 60371 of the final rule.

II.A.2.d.4. Echocardiography Services (74FR60374)

CPT code 93351, Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report, including performance of continuous electrocardiographic monitoring, with physician supervision, has been reassigned to APC 0270, Level III Echocardiogram without Contrast.

HCPCS codes C8921, C8925, C8926, and C8930 have been assigned to APC 0128, Echocardiogram with contrast.

Table 9 on page 60380 of the final rule shows CY 2010 CPT codes for billing echocardiography services without contrast, their final APC assignments for CY 2010, and the corresponding HCPCS codes for use when echocardiography services are performed with contrast (or without contrast followed by with contrast), along with their final APC assignments for CY 2010.

APCs 0269, 0270, and 0697 have been renamed:

0269 –Level II Echocardiogram Without Contrast
 0270 – Level III Echocardiogram Without Contrast
 0697 – Level I Echocardiogram Without Contrast

II.A.2.d.5. Nuclear Medicine Services (74FR60384)

CPT code 78003, Thyroid uptake; stimulation, suppression or discharge (not including initial uptake studies) has been reassigned to APC 0414, Level II Tumor/Infection Imaging.

CMS has assigned:

CPT code 78000 to APC 0389
 CPT code 78001 to APC 0389
 CPT code 78003 to APC 0389
 CPT code 78601 to APC 0402
 CPT code 78610 to APC 0403
 CPT code 78645 to APC 0403
 CPT code 78807 to APC 0406
 CPT code 79608 to APC 0308

II.A.2.e.1. Extended Assessment and Management Composite APCs (74FR60392)

CMS will continue to include composite APCs 8002 and 8003 in the OPSS and continue the extended assessment and management composite APC payment methodology and criteria that were finalized for CY 2009.

II.A.2.e.4. Mental Health Services Composite APC (74FR60397)

CMS has limited the aggregate payment for specified less intensive outpatient mental health services furnished on the same day by a hospital to the payment for a day of partial hospitalization, specifically APC 0173.

Status indicator “Q3” has been assigned to those HCPCS codes that describe the specified mental health services to which APC 0034 applies in Addendum B to this final rule.

II.A.4.b.2. Packaged Services Addressed by the August 2009 APC Panel Recommendations (74FR60413)

CMS finalized their CY 2010 proposals to package payment for the seven categories of services, including guidance services, image processing services, intraoperative services, imaging supervision and interpretation services, diagnostic radiopharmaceuticals, contrast media, and observation services.

II.A.4.b.3. Other Service-Specific Packaging Issues (74FR60417)

CPT code 76098, Radiological examination, surgical specimen, has been assigned status indicator “Q2” to signify that the service is packaged when it is reported with a separately paid procedure that has a status indicator of “T” on the same date of service and separately paid under APC 0317, Level II Miscellaneous Radiology Procedures, when it is not reported on the same date of service with a separately paid surgical procedure that has a status indicator of “T.”

III. OPSS Ambulatory Payment Classification (APC) Group Policies (74FR60431)

III.A.1. Treatment of New Level II HCPCS Codes and Category I CPT Vaccine Codes and Category III CPT Codes (74FR60432)

The new level II HCPCS codes implemented in April 2009 and July 2009 have been assigned to the APCs listed in Tables 19 and 20 on pages 60433 and 60434 of the final rule.

The APC assignments for CPT codes 0199T, 0299T, 0201T, 0202T, and 90670 are listed in Table 21 on page 60434 of the final rule.

III.C.2. Movement of Procedures from New Technology APCs to Clinical APCs (74FR60438)

CPT code 0182T, High dose rate electronic brachytherapy, per fraction, has been assigned to APC 0313, Brachytherapy.

III.D.1.b. Implantable Loop Recorder Monitoring (74FR60441)

CPT code 93299, Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system or implantable loop recorder system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results, has been reassigned to APC 0689, Level II Electronic Analysis of Devices.

CPT code 75978, Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation, has been reassigned to APC 0093, Vascular Reconstruction/Fistula Repair without Device.

III.D.2.a. Change of Gastrostomy Tube (74FR60441)

CPT code 43760, Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance, has been reassigned to APC 0676, Thrombolysis and Other Device Revisions.

III.D.2.b. Laparoscopic Liver Cryoablation (74FR60442)

CPT code 47371, Laparoscopy, surgical, ablation of 1 or more liver tumor(s); cryosurgical, has been reassigned to APC 0174, Level IV Laparoscopy.

III.D.2.d. Laparoscopic Hernia Repair (74FR60443)

CPT codes 49652, 49653, 49654, 49655, 49656, and 49657, have been reassigned to APC 0132, Level III Laparoscopy.

III.D.3.d. Change of Bladder Tube (74FR60446)

CPT code 51710, Change of cystostomy tube; complicated, has been reassigned to APC 0121, Level I Tube or Catheter Changes or Repositioning.

III.D.6.a. Arthroscopic Procedures (74FR60449)

CPT codes 29888, Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction, and 29889, Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction, have been reassigned to APC 0052, Level IV Musculoskeletal Procedures Except Hand and Foot.

CPT code 29892, Arthroscopically aided repair of large osteochondritis dissecans lesion, talar dome fracture, or tibial plafond fracture, with or without internal fixation (includes arthroscopy), has also been reassigned to APC 0052.

III.D.6.d. Fasciotomy Procedures (74FR60451)

CPT codes 25020, 27496, 27498, 27499, 27892, 27893, and 27894 to APC 0050, Level II Musculoskeletal Procedures Except Hand and Foot.

III.D.6.e. Fibula Repair (74FR60451)

CPT code 27726, Repair of fibula nonunion and/or malunion with internal fixation, has been reassigned to APC 0063, Level II Treatment Fracture/Dislocation.

III.D.6.f. Forearm Orthopedic Procedures (74FR60451)

CPT codes 24400, 24410, 25350, 25360, 25365, and 25390 have been assigned to APC 051, Level III Musculoskeletal Procedures Except Hand and Foot.

III.D.8.a. Low Frequency, Non-Contact, Non-Thermal Ultrasound (74FR60458)

CPT code 0183T, Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day, has been reassigned to APC 0013, Level II Debridement & Destruction.

III.D.8.b. Skin Repair (74FR60459)

The Apligraf and Dermagraft application CPT codes (codes 15340, 15341, 15365, 15366) will continue to be assigned to APC 0134, and the Oasis application CPT codes (codes 15430 and 15431) will continue to be assigned to APC 0135. CMS noted that when hospitals perform these procedures, they would also report the Level II HCPCS codes that describe the biological products that are used with the Apligraf, Dermagraft, and Oasis application CPT codes, which are paid separately in CY 2010.

CMS accepted the APC Panel's recommendation that data on the frequency of primary and add-on CPT codes billed for Apligraf, Oasis, and Dermagraft application be provided at the next APC Panel meeting in order to assess the apparent variability in billing for the application of these products. CMS also accepted the APC Panel's recommendation that median cost data for site preparation and debridement that may be separately reported in preparation for application of Dermagraft be provided to them. The requested data will be provided at the winter 2010 APC Panel meeting.

IV. OPSS Payment for Devices (74FR60462)***IV.A.2.b. Provisions for Reducing Transitional Pass-Through Payments to Offset Costs Packaged into APC Groups – Final Policy (74FR60463)***

Device pass-through payments have been reduced based on device costs already included in the associated procedural APCs, when CMS determines that device costs associated with the new category are already packaged into the existing APC structure.

IV.B.2. APCs and Devices Subject to the Adjustment Policy (74FR60464)

Table 28 on page 60465 of the final rule lists the APCs to which the no cost/full credit and partial credit device adjustment policy applies.

Table 29 on page 60466 of the final rule lists the device codes to which the no cost/full credit and partial credit device adjustment policy applies.

Device HCPCS code L8680, Implantable neurostimulator electrode, each, has been added to the list of devices in Table 29 because CMS changed the status indicator for this code from “B” (Codes that are not recognized by OPSS when submitted on an outpatient hospital Part B bill type (12x and 13x)) to “N” (Items and services packaged into APC rates). This change in status indicator does not require hospitals to change their current billing practices, but it does provide them with the flexibility to use this code if they choose to do so.

V. OPSS Payment Changes for Drugs, Biologicals, and Radiopharmaceuticals (74FR60466)

V.A.2. Drugs and Biologicals with Expiring Pass-Through Status in CY 2009 (74FR60467)

The pass-through status of the following drugs and biologicals has expired, effective December 31, 2009:

C9354, Acellular pericardial tissue matrix of non-human origin (Veritas), per square centimeter

C9355, Collagen nerve cuff (NeuroMatrix), per 0.5 centimeter length

J1300, Injection, eculizumab, 10 mg

J3488, Injection, zoledronic acid (Reclast), 1 mg

J9261, Injection, nelarabine, 50 mg

J9330, Injection, temsirolimus, 1 mg

V.A.3. Drugs, Biologicals, and Radiopharmaceuticals with New or Continuing Pass-Through Status in CY 2010 (74FR60468)

The drugs and biological with pass-through status in CY 2010 are listed in Table 31 on page 60470 of the final rule.

V.A.4. Pass-Through Payment for Implantable Biologicals (74FR60471)

The pass-through evaluation process and payment methodology for implantable biological that are surgically inserted or implanted (through a surgical incision or a natural orifice), and that are newly approved for pass-through status beginning on or after January 1, 2010, is the device pass-through process and payment methodology only. However, those implantable biological that are surgically inserted or implanted and that are receiving pass-through payment as biological prior to January 1, 2010 would continue

to be considered pass-through biologicals for the duration of their period of pass-through payment.

V.B.2.b. Cost Threshold for Packaging of Payment of HCPCS Codes that Describe Certain Drugs, Nonimplantable Biologicals, and Therapeutic Radiopharmaceuticals (“Threshold-Packaged Drugs”) (74FR60485)

The drug packaging methodology has been applied to all 5-HT3 antiemetics for CY 2010. CMS is not providing any exceptions to the standard drug packaging methodology for any class of drugs, including anticoagulants and anticancer therapies, for CY 2010.

V.B.2.c. Packaging Determination for HCPCS Codes that Describe the Same Drug or Biological but Different Dosages (74FR60490)

CMS will make a single packaging determination for a drug, rather than an individual HCPCS code, when a drug has multiple HCPCS codes describing different dosages.

Table 35 on page 60492 of the final rule lists the HCPCS codes to which the CY 2010 drug-specific packaging determination methodology applies.

V.B.2.d. Packaging of Payment for Diagnostic Radiopharmaceuticals, Contrast Agents, and Implantable Biologicals (“Policy-Packaged” Drugs and Devices) (74FR60495)

Payment for all nonpass-through diagnostic radiopharmaceuticals, contrast agents, and implantable biological that are surgically inserted or implanted into the body, regardless of their per day costs, will continue to be packaged. Given the inherent function of contrast agents and diagnostic radiopharmaceuticals as ancillary and supportive to the performance of an independent procedure and the similar functions of implantable biological and nonbiological devices, CMS continues to view the packaging of payment for contrast agents, diagnostic radiopharmaceuticals, and implantable biologicals as a logical expansion of packaging payment for drugs and biologicals.

VIII. OPPS Payment for Drug Administration Services (74FR60537)

VIII.B. Coding and Payment for Drug Administration Services (74FR60538)

CPT code 96521, Refilling and maintenance of portable pump, has been reassigned to APC 0439, Level IV Drug Administration.

All separately payable drug administration add-on codes have been included on the bypass list for CY 2010.

The five-level APC structure for payment of drug administration services will continue.

Payment for CPT codes 96376, Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of the same

substance/drug provided in a facility (List separately in addition to code for primary procedure), and 96368, Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure), will continue to be packaged for CY 2010.

Table 46 on page 60541 displays the final configurations of the five drug administration APCs for CY 2010.

IX. OPPS Payment for Hospital Outpatient Visits (74FR60545)

IX.B.1. Clinic Visits: New and Established Patient Visits (74FR60546)

New or established patient status for the purpose of reporting the clinic visit CPT codes will continue to be defined on the basis of whether or not the patient has been registered as an inpatient or outpatient of the hospital within the past 3 years.

Because hospital claims data continue to show significant cost differences between new and established patient visits, CMS continues to believe it is necessary and appropriate to recognize the CPT codes for both new and established patient visits and, in some cases, provide differential payment for new and established patient visits of the same level.

IX.B.2. Emergency Department Visits (74FR60548)

Type B emergency department visits will continue to be paid through a five-level APC structure.

IX.B.3. Visit Reporting Guidelines (74FR60552)

CMS noted that many commenters indicated the American Hospital Association will reconvene an expert panel to submit a request to the American Medical Association CPT Editorial Panel to create CPT codes for hospital visits and encouraged CMS to be engaged in and supportive of the recommendations of the expert panel. CMS stated they look forward to reviewing any recommendations that result from the AHA-convened expert panel. If the AMA were to create facility-specific CPT codes for reporting visits provided in hospital outpatient departments, CMS would consider such codes for OPSS use.

XI. Procedures That Will be Paid Only as Inpatient Procedures (74FR60560)

XI.B. Changes to the Inpatient List (74FR60561)

Eight CPT codes have been removed from the inpatient list:

21256, Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (includes obtaining autografts) (eg, micro-ophthalmia)

27179, Open treatment of slipped femoral epiphysis; osteoplasty of femoral neck (Heyman type procedure)
 28805, Amputation, foot; transmetatarsal
 37215, Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection
 44950, Appendectomy
 44955, Appendectomy; when done for indicated purpose at time of other major procedure (not as separate procedure) (List separately in addition to code for primary procedure)
 51060, Transvesical ureterolithotomy
 63076, Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophyectomy; cervical, each additional interspace (List separately in addition to code for primary procedure)

XII.OPPS Nonrecurring Technical and Policy Changes and Clarifications (74FR60564)

XII.B.1. Pulmonary Rehabilitation, Cardiac Rehabilitation, and Intensive Cardiac Rehabilitation Services – Legislative Changes (74FR60566)

Medicare Part B coverage and payment for pulmonary and cardiac rehabilitation services furnished to beneficiaries with chronic obstructive pulmonary disease and certain other conditions became effective January 1, 2010.

CMS noted that they plan to monitor claims data for pulmonary rehabilitation (PR), cardiac rehabilitation (CR), and intensive cardiac rehabilitation (ICR) services, as well as any additional claims for therapy services. If they detect patterns of care that are inconsistent with their stated expectations for PR, CR, or ICR services and therapy services, Medicare contractors may be encouraged to review cases in which a hospital reports both types of services for the same patient during the same span of time (for example, over a several month period) or CMS may propose changes to their payment methodologies for these services.

CMS expects component services that are furnished under a PR, CR, or ICR treatment plan to beneficiaries who qualify for PR, CR, or ICR services to be furnished as PR, CR, or ICR services, regardless of whether are furnished by a physical therapist or other healthcare practitioner, and that all of the coverage and payment requirements for hospital outpatient services, including, but not limited to, the physician supervision requirements for hospital outpatient therapeutic services, apply to those PR, CR, or ICR services.

XII.B.2. Payments for Services Furnished to Hospital Outpatients in a Pulmonary Rehabilitation Program (74FR60567)

HCPCS code G0424, Pulmonary rehabilitation, including exercise (includes monitoring), per hour, per session, has been created to identify services provided as part of a PR program. This code has been assigned to APC 0102, Level II Pulmonary Treatment. PR

is covered for up to 36 one-hour sessions, with a maximum of 2 sessions per day, and with contractor discretion to approve up to 72 sessions.

XII.B.3. Payment for Services Furnished to Hospital Outpatients Under a Cardiac Rehabilitation or an Intensive Cardiac Rehabilitation Program (74FR60570)

The CPT codes for CR, codes 93797, Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session) and 93798, Physician services for outpatient cardiac rehabilitation, with continuous ECG monitoring (per session), will continue to be assigned to APC 0095, Cardiac Rehabilitation. CR is covered for up to 36 one-hour sessions, with a minimum of 1 session per week and a maximum of 2 sessions per day, and Medicare contractors have the authority to approve additional sessions, up to 72 hour sessions, over an additional period of time.

HCPCS codes G0422, Intensive cardiac rehabilitation; with or without continuous ECG monitoring, with exercise, per hour, per session, and G0423, Intensive cardiac rehabilitation; with or without continuous ECG monitoring, without exercise, per hour, per session) have been created for ICR services. These codes will be assigned to APC 0095. Coverage of up to 72 one-hour ICR sessions is allowed by law. Payment for ICR services has been established on the presumption that one session represents one hour of care.

XII.D.5. Summary of CY 2010 Physician Supervision Final Policy (74FR60591)

For CY 2010, nonphysician practitioners who are clinical psychologists, licensed clinical social workers, physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse-midwives, may directly supervise all hospital outpatient therapeutic services that they may perform themselves within their State scope of practice and hospital-granted privileges, provided that they meet all additional requirements.

For PR, CR, and ICR services, direct supervision must be furnished by a doctor of medicine or osteopathy.

For services provided in the hospital or on-campus provider-based department (PBD) of the hospital, direct supervision means that the physician or nonphysician practitioner must be present on the same campus and immediately available to furnish assistance and direction throughout the performance of the procedure.

For off-campus PBDs of hospitals, the physician or nonphysician practitioner must be present in the off-campus PBD and immediately available to furnish assistance and direction throughout the performance of the procedure. This requirement does not mean the physician or nonphysician practitioner must be in the room where the procedure is performed.

XII.E. Direct Referral for Observation Services (74FR60591)

The descriptor of HCPCS code G0379 has been revised to state “Direct referral for hospital observation care.”

XV. Updates to the Ambulatory Surgical Center (ASC) Payment System (74FR60596)

XV.B.2. Treatment of New Level II HCPCS Codes Implemented in April and July 2009 (74FR60600)

The ASC payment indicators for the new Level II HCPCS codes implemented in April and July 2009 are listed in Tables 58 and 59 on page 60601 of the final rule.

XV.C.1.a. Additions to the List of ASC Covered Surgical Procedures (74FR60602)

Twenty-eight (28) procedures have been added to the CY 2010 ASC list and two Level II HCPCS codes have been deleted. The procedures that have been added can be found in Table 62 and the deleted HCPCS codes are listed in Table 63 of the final rule. Both tables are on page 60604.

XV.C.1.c.2. Changes to List of Covered Surgical Procedures Designated as Device-Intensive for CY 2010 (74FR60608)

The ASC covered surgical procedures designated as device-intensive for CY 2010 are listed in Table 68 on page 60610 of the final rule.

XV.C.1.d. ASC Treatment of Surgical Procedures Removed from the OPPI Inpatient List for CY 2010 (74FR60611)

The procedures that have been removed from the CY 2010 OPPI inpatient list but that continue to be excluded from the ASC list of covered surgical procedures are:

- 21256, Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (includes obtaining autografts) (eg, micro-ophthalmia)
- 27179, Open treatment of slipped femoral epiphysis; osteoplasty of femoral neck (Heyman type procedure)
- 28805, Amputation foot; transmetatarsal
- 37215, Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection
- 44950, Appendectomy
- 44955, Appendectomy; when done for indicated purpose at time of other major procedure (not as separate procedure) (List separately in addition to code for primary procedure)
- 51060, Transvesical ureterolithotomy
- 63076, Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophylectomy; cervical, each additional interspace (List separately in addition to code for primary procedure)

XV.D.1.c. Adjustment to ASC Payments for No Cost/Full Credit and Partial Credit Devices (74FR60613)

For CY 2010, the payment for the device implantation procedures listed in Table 70 of the final rule (page 60615) will be reduced by the full device offset amount for no cost/full credit cases. ASCs must append the modifier “FB” to the HCPCS procedure code when the device furnished without cost or with full credit is listed in Table 71 of the final rule (page 60617), and the associated implantation procedure code is listed in Table 70.

In addition, the payment for implantation procedures listed in Table 70 will be reduced by one half of the device offset amount that would be applied if a device were provided at no cost or with full credit, if the credit to the ASC is 50 percent or more of the device cost. If the ASC receives a partial credit of 50 percent or more of the cost of a device listed in Table 71, the ASC must append the modifier “FC” to the associated implantation procedure code if the procedure is listed in Table 70.

Device HCPCS code L8680, Implantable neurostimulator electrode, each, has been added to the list of devices in Table 71 because this code is packaged under the OPPS for CY 2010.

XVI. Reporting Quality Data for Annual Payment Rate Updates (74FR60629)

XVI.B.2. Retirement of HOP QDRP Quality Measures (74FR60634)

CMS will promptly retire measures under circumstances in which they receive evidence that continued collection of a measure that has been adopted for the Hospital Outpatient Quality Data Reporting Program (HOP QDRP) raises patient safety concerns, to notify hospitals and the public of the retirement of the measure and the reasons for its retirement through the usual means by which CMS communicates with hospitals, including, but not limited to, hospital email blasts and the QualityNet web site, and to confirm the retirement of measures retired in this manner in the next rulemaking cycle.

XVI.B.3. HOP QDRP Quality Measures for the CY 2011 Payment Determination (74FR60635)

CMS has decided to retain the existing 11 HOP QDRP measures without adding new measures to the measure set for the CY 2011 payment determination. The measure set that will be used for the CY 2011 payment determination is:

- OP-1: Median Time to Fibrinolysis
- OP-2: Fibrinolytic Therapy Received Within 30 Minutes
- OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention
- OP-4: Aspirin at Arrival
- OP-5: Median Time to ECG
- OP-6: Timing of Antibiotic Prophylaxis

- OP-7: Prophylactic Antibiotic Selection for Surgical Patients
- OP-8: MRI Lumbar Spine for Low Back Pain
- OP-9: Mammography Follow-up Rates
- OP-10: Abdomen CT – Use of Contrast Material
- OP-11: Thorax CT – Use of Contrast Material