CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 599

Department of Health & Human Services

Center for Medicare and & Medicaid Services

Date: June 30, 2005

Change Request 3915

NOTE: *Transmittal 585, dated June 17, 2005 is rescinded and replaced with Transmittal 599, dated June 30, 2005. There were changes in the Policy section B.3. All other information remains the same.*

SUBJECT: July 2005 Update of the Hospital Outpatient Prospective Payment System (OPPS)

I. SUMMARY OF CHANGES: This Recurring Update Notification describes changes to the OPPS, to be implemented in the July 2005 update. This notification further describes changes to payment policy and billing procedures under the OPPS.

NEW/REVISED MATERIAL :

EFFECTIVE DATE : July 01, 2005

IMPLEMENTATION DATE : July 05, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R = REVISED, N = NEW, D = DELETED – *Only One Per Row.*

R/N/D	Chapter / Section / SubSection / Title
N/A	

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.

IV. ATTACHMENTS:

Recurring Update Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 599	Date: June 30, 2005	Change Request 3915

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SUBJECT: July 2005 Update of the Hospital Outpatient Prospective Payment System (OPPS)

I. GENERAL INFORMATION

A. Background: This Recurring Update Notification describes changes to the OPPS, to be implemented in the July 2005 update. This notification further describes changes to payment policy and billing procedures under the OPPS. The July 2005 OPPS OCE and OPPS PRICER will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in this notification. Unless otherwise noted, all changes addressed in this notification are effective for services furnished on or after July 1, 2005. July 2005 revisions to the OPPS OCE data files, instructions, and specifications are provided in Change Request 3871, 'July 2005 Outpatient Prospective Payment System Code Editor (OPPS OCE) Specifications Version 6.2.'

B. Policy:

1. Smoking and Tobacco-Use Cessation Counseling Services

Effective March 22, 2005, the Centers for Medicare and Medicaid Services (CMS) determined that the evidence is adequate to conclude that smoking and tobacco use cessation counseling is reasonable and necessary for a patient with a disease or an adverse health effect that has been found by the U.S. Surgeon General to be linked to tobacco use, or who is taking a therapeutic agent whose metabolism or dosing is affected by tobacco use as based on FDA-approved information. These individuals will be covered under Medicare Part B when certain conditions of coverage are met, subject to certain frequency and other limitations. Conditions of Medicare Part A and Medicare Part B coverage for smoking and tobacco-use cessation counseling services are located in the Medicare National Coverage Determinations Manual, Publication 100-3, Section 210.4.

Effective for services furnished on or after March 22, 2005, hospitals should report the following HCPCS codes when billing for smoking and tobacco-use cessation counseling service:

HCPCS	SI	Descriptor	APC
G0375	S	Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes Short Descriptor: Smoke/Tobacco counseling 3-10	1501

G0376	S	Smoking and tobacco-use cessation counseling visit; intensive, greater than 10 minutes Short Descriptor: Smoke/Tobacco counseling greater than 10	1501

NOTE: The above G codes will NOT be active in contractors' systems until July 5, 2005. Refer to CR 3834, Business Requirements 3834.15 through 3834.18, for detailed business requirements related to reporting smoking and tobacco use cessation counseling furnished by hospitals and paid under the OPPS. This coverage decision, as described in the Medicare National Coverage Determinations Manual (Publication 100-3, section 210.4), does not modify existing coverage for minimal cessation counseling (defined as 3 minutes or less in duration) which is already considered to be covered as part of each Evaluation and Management (E/M) visit and is not separately billable.

2. Drugs and Biologicals

a. Drugs with Payments Based on Average Sales Price (ASP) Effective July 1, 2005

The table below lists the drugs and biologicals whose payments under the OPPS will be established in accordance with the ASP methodology that is used to calculate payment for drugs and biologicals in the physician office setting. In the 2005 OPPS final rule (69 FR 65777), it was stated that payments for drugs and biologicals based on ASP will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary, we will incorporate changes to the payment rates in an appropriate quarterly release of the OPPS PRICER and we will not be publishing the updated payment rates in the program instructions implementing the associated quarterly update of the OPPS. However, the updated payment rates can be found in the July update of OPPS Addendum A and Addendum B on the CMS web site.

Single-indication orphan drugs payable under OPPS are also listed below. The methodology used to establish payment rates for these drugs is discussed in the 2005 OPPS final rule (69 FR 65807).

HCPCS	APC	Long Description
C9123	9123	Human fibroblast derived temporary skin substitute, per 247 square centimeters
C9127	9127	Injection, paclitaxel protein-bound particles, per 1 mg
C9128	9128	Injection, pegaptamib sodium, per 0.3 mg
C9129	9129	Injection, Clofarabine, per 1 mg
C9203	9203	Injection, Perflexane lipid microspheres, per single use vial
C9205	9205	Injection, Oxaliplatin, per 5 mg
C9206	9206	Collagen-glycosaminoglycan bilayer matrix, per cm2
C9211	9211	Injection, Alefacept, for intravenous use per

		7.5 mg
C9212	9212	Injection , Alefacept, for intramuscular use per 7.5 mg
C9218	9218	Injection, azacitidine, 1 mg
C9220	9220	Sodium hyaluronate per 30 mg dose, for intra-articular injection
C9221	9221	Acellular dermal tissue matrix, per 16cm2
C9222	9222	Decellularized soft tissue scaffold, per 1 cc
J0128	9216	Abarelix for injectable suspension, per 10 mg
J0135	1083	Injection, adalimumab, 20 mg
J0180	9208	Injection, IV, Agalsidase beta, per 1 mg
J0205	900	Injection, Alglucerase, per 10 units
J0256	901	Alpha 1 proteinase inhibitor-human, 10 mg
J0595	703	Injection, Butorphanol tartrate 1 mg
J0878	9124	Injection, daptomycin per 1 mg
J1457	1085	Injection, gallium nitrate, 1 mg
J1785	916	Injection imiglucerase, per unit
J1931	9209	Injection, laronidase, 0.1 mg
J2185	729	Injection, meropenem, 100 mg
J2280	1046	Injection, moxifloxacin 100 mg
J2355	7011	Oprelvekin injection, 5 mg
J2357	9300	Injection, omalizumab, per 5 mg
J2469	9210	Injection, palonosetron HCI, 25 mcg
J2783	738	Injection, rasburicase, 0.5 mg
J2794	9125	Injection, risperidone, long acting, 0.5 mg
J3240	9108	Injection Thyrotropin Alpha , 0.9 mg, provided in 1.1 mg vial
J3411	1049	Injection, Thiamine HCL 100 mg
J3415	1050	Injection, Pyridoxine HCL 100 mg
J3465	1052	Injection, voriconazole, 10 mg
J3486	9204	Injection, Ziprasidone mesylate, per 10 mg
J7308	7308	Aminolevulinic acid HCL for topical administration, 20%, single unit dosage form (354mg)
J7513	1612	Daclizumab, parenteral, 25 mg
J7518	9219	Mycophenolic acid, oral, per 180 mg
J7674	867	Methacholine chloride administered as inhalation solution through a nebulizer, per 1mg
J8501	868	Aprepitant, oral, 5 mg
J9010	9110	Alemtuzumab, 10 mg
J9015	807	Aldesleukin, per single use vial
J9017	9012	Arsenic trioxide, 1 mg
J9035	9214	Injection, Bevacizumab, per 10 mg

J9041	9207	Injection, Bortezomib, 0.1 mg
J9055	9215	Injection, Cetuximab, per 10 mg
J9160	1084	Denileukin diftitox, 300 mcg
J9216	838	Interferon gamma 1-b, 3 million units
J9300	9004	Gemtuzumab ozogamicin, 5 mg
J9305	9213	Injection, Pemetrexed, per 10 mg
Q2019	1615	Injection, Basiliximab, 20 mg
Q4075	1062	Injection, Acyclovir, 5 mg
Q4076	1070	Injection, Dopamine HCL, 40 mg
Q4077	1082	Injection, Treprostinil, 1 mg
Q4079	9126	Injection, Natalizumab, per 1 mg

b. Updated Payment Rates for Certain Drugs, Biologicals and Services Effective April 1, 2005 through June 30, 2005

The payment rate for the drug listed below was incorrect in the April 2005 OPPS PRICER. The corrected payment rate will be installed in the July 2005 OPPS PRICER, effective for services furnished on April 1, 2005 through implementation of the July 2005 update. By September 15, 2005, Fiscal Intermediaries shall mass adjust all claims with dates of service on or after April 1, 2005 through implementation of the July 2005 update, that were processed to payment between April 1, 2005 and July 5, 2005 (implementation of the July 1, 2005 OPPS OCE update), containing J0135, correcting the payment rate to $294.63.

HCPCS	APC	Long Description	Corrected Payment Rate
J0135	1083	Injection, Adalimumab, 20 mg	$294.63

c. Newly-Approved Drugs and Biologicals Eligible for Pass-Through Status

The following drugs and biologicals have been designated as eligible for pass-through status under the OPPS effective July 1, 2005. Payment rates for these items can be found in the July update of OPPS Addendum A and Addendum B on the CMS web site.

HCPCS	APC	SI	Long Description
C9127	9127	G	Injection, Paclitaxel Protein Bound Particles, per 1 mg
C9128	9128	G	Injection, Pegaptiamib Sodium, per 0.3 mg
C9129	9129	G	Injection, Clofarabine, per 1 mg
J8501*	0868	G	Aprepitant, oral, 5 mg

*J8501 was approved for pass-through status effective April 6, 2005.

3. Medical Nutrition Therapy Services

If a medical nutrition therapy service is provided in the hospital outpatient department, hospitals should bill their local Fiscal Intermediary (FI) using the UB-92 for an evaluation and management code. Hospitals should be reporting CPT codes 97802, 97803, and 97804 for medical nutrition therapy services to FIs using the UB-92 or its electronic equivalent.

4. Reprocessing of OPPS Claims Containing Certain Surgical Procedures

The CMS discovered an error in the 2005 OPPS PRICER that miscalculates the outlier payment amount. The CMS has corrected the problem in the July 2005 version of the OPPS PRICER software. By September 15, 2005, FIs shall mass adjust claims that meet all of the following criteria using the July 2005 OPPS PRICER:

1) Claims processed using the January or April 2005 OPPS PRICER that were processed to payment prior to installation of the July 2005 OPPS PRICER; and
2) Claims with one or more surgical procedure lines (lines with a status indicator of "T" (any HCPCS) or "S" with HCPCS codes greater than 09999 and less than 70000) that contain no surgical procedure lines with charges less than $1.01; and
3) Claims with dates of service January 1, 2003 or greater.

Note: The MSP mass adjustment instructions included in JSM-05356, issued on May 20, 2005, also apply to these reprocessed claims.

5. No-Cost Device Coding

Effective for services furnished on or after April 1, 2005, all hospitals paid under the OPPS must report a code for a device when reporting the code for inserting the device. (See Transmittal 403, CR 3606, issued December 17, 2004.) If an OPPS hospital fails to report a device code, edits installed in the outpatient code editor (OCE) for services furnished on or after April 1, 2005 will not allow the claim to be processed to payment. For example, if a hospital doesn't report the code for a pacemaker with the CPT code for the procedure performed to insert the pacemaker, OCE edits will cause the claim to be returned to the provider.

However, there are occasions when a hospital may furnish a device for surgical insertion for which it incurs no cost. These cases include, but are not limited to, devices replaced under warranty, due to recall, or due to defect in a previous device; devices provided in a clinical trial; or devices provided as a sample. The hospital charge for a device furnished to the hospital at no cost should equal $0.00. Some hospitals paid under the hospital outpatient prospective payment system (OPPS) might ordinarily report neither a code nor a charge for a device for which it incurred no cost, which would result in the claim failing the device edits installed in the OCE. Other hospitals have billing systems which require that a charge be reported for separately payable codes in order for the claim to be submitted for payment, even items for which the hospital incurs no cost.

Hospitals paid under the OPPS have asked that CMS clarify how devices furnished to beneficiaries for which the hospital incurs no cost should be reported. Therefore, take immediate

action to broadcast and disseminate the following instructions to hospitals for services furnished on or after April 1, 2005:

- Hospitals paid under the OPPS that surgically implant a device furnished at no cost to the hospital shall report the appropriate HCPCS code for the device on type of bill 13x.
- Hospitals paid under the OPPS that surgically implant a device furnished at no cost to the hospital shall report a charge of zero for the device, or, if the hospital's billing system requires that a charge be entered, the hospital shall submit a token charge (e.g. $1.00) on the line with the device code.

We recognize that showing a charge for a device that has been furnished without cost is not optimal, but showing a token charge in this circumstance will allow claims for reasonable and necessary services that might otherwise be denied due to OCE edits to be paid, and will ensure that beneficiaries receive the care they need.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers			Other	
						FISS	MCS	VMS	CWF	
3915.1	The FISS maintainer shall install the July 2005 OPPS PRICER.					X				
3915.2	By September 15, 2005, Fiscal Intermediaries shall mass adjust claims that meet all of the following criteria, through the July 2005 OPPS PRICER: 1) Claims processed using the January or April 2005 OPPS PRICER that were processed to payment prior to installation of the July 2005 OPPS PRICER; and 2) Claims with one or more surgical procedure lines (lines with a status indicator of "T" (any HCPCS) or "S" with HCPCS codes greater than 09999 and less than 70000) that contain no surgical procedure lines with charges less than $1.01; and 3) Claims with dates of service January 1, 2003 or greater.	X	X							

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers			Other	
						FISS	MCS	VMS	CWF	
3915.3	By September 15, 2005, Fiscal Intermediaries shall mass adjust all claims with dates of service on or after April 1, 2005 through implementation of the July 2005 update, that were processed to payment between April 1, 2005 and July 5, 2005 (implementation of the July 1, 2005 OPPS OCE update), containing J0135, correcting the payment rate to $294.63.	X	X							
3915.4	The SSM shall provide FI's with the SuperOp event for creation of the mass adjustments listed in this CR.					X				

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3915.1	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic.	X	X							

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: July 1, 2005 **Implementation Date:** July 5, 2005 **Pre-Implementation Contact(s):** Melissa Dehn melissa.dehn@cms.hhs.gov; Marina Kushnirova marina.kushnirova@cms.hhs.gov **Post-Implementation Contact(s):** Appropriate Regional Office	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2005 operating budgets.**

*Unless otherwise specified, the effective date is the date of service.