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Implementation Date: April 3, 2006

April 2006 Update of the Hospital Outpatient Prospective Payment System (OPPS): Summary of Payment Policy Changes

Note: This article was updated on November 1, 2012, to reflect current Web addresses. All other information remains unchanged.

Provider Types Affected

Providers billing Medicare fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), for services under the hospital OPPS.

Provider Action Needed

This article is based on Change Request (CR) 5011 which describes changes to the OPPS to be implemented in the April 2006 OPPS update.

Background

Change Request (CR) 5011 describes changes to the hospital Outpatient Prospective Payment System (OPPS) to be implemented in the April 2006 OPPS update. The April 2006 OPPS Outpatient Code Editor (OCE) and OPPS PRICER will reflect the Healthcare Common Procedure Coding System (HCPCS) and Ambulatory Payment Classification (APC) additions, changes, and deletions identified in CR5011.

In addition, the April 2006 revisions to the OPPS OCE data files, instructions, and specifications are provided in CR4360 (April 2006 Outpatient Prospective Payment System Code Editor (OPPS OCE) Specifications Version 7.1. CR4360 can be found at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R888CP.pdf> on the CMS website.

Key changes in CR5011 are as follows:

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Billing Clarification for Intensity Modulated Radiation Therapy (IMRT)

Intensity modulated radiation therapy (IMRT), also known as **conformal radiation**, delivers radiation with adjusted intensity to preserve adjoining normal tissue. IMRT has the ability to deliver a higher dose of radiation within the tumor while delivering a lower dose of radiation to surrounding healthy tissue, and it is provided in two treatment phases, planning and delivery. The two methods by which IMRT can be delivered to patients include:

- Multi-leaf collimator-based IMRT, and
- Compensator-based IMRT.

The Centers for Medicare & Medicaid Services (CMS) has received several inquiries seeking clarification of the appropriate billing of certain radiation oncology services when such services are performed in conjunction with an IMRT planning service. Clarification of CMS billing policy is provided below under subsection (a), and billing instructions are described under subsections (b) through (e).

These instructions remain unmodified since the issuance of CR4250 (Transmittal 804, dated January 3, 2006, at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R804CP.pdf> on the CMS website. The MLN Matters article corresponding to CR4250 can be found at <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM4250.pdf> on the CMS website.

Effective January 1, 2006, when IMRT is furnished to beneficiaries in a hospital outpatient department that is paid under the hospital OPDS, hospitals should bill according to the following guidelines:

- a. Do not report Current Procedural Terminology (CPT) codes 77280-77295, 77305-77321, 77331, 77336, and 77370 when these services are directly linked to and performed **as part of developing an IMRT plan** that is reported using CPT code 77301 (IMRT treatment planning).

When the above-mentioned services are performed as part of developing an IMRT plan, the charges for these services should be included in the charge associated with CPT code 77301, even if the individual services associated with IMRT planning are performed on dates of service other than the date on which CPT code 77301 is reported.

- b. Hospitals are not prohibited from using existing CPT code 77301 to bill for compensator-based IMRT planning in the hospital outpatient setting.
- c. As instructed in the 2006 CPT manual, hospitals should bill CPT code 77418 for multi-leaf collimator-based IMRT delivery and Category III CPT code 0073T for compensator-based IMRT delivery in the hospital outpatient setting.

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- d. Payment for IMRT planning does not include payment for CPT codes 77332 - 77334 when furnished on the same day. When services described by CPT codes 77332 - 77334 are furnished on the same date of service with 77301, these services are to be billed in addition to the IMRT planning code 77301.
- e. Providers billing for both CPT codes 77301 (IMRT treatment planning) and 77334 (design and construction of complex treatment devices) on the same day should append a modifier -59.

Provider Information on Drug Administration Correct Coding Initiative (CCI) Edits

Beginning in April 2006, Correct Coding Initiative (CCI) edits will be activated under the OPSS for drug administration services. CMS developed the CCI to promote national correct coding methodologies and to prevent improper coding that could lead to inappropriate Part B payments. Appropriate CCI edits already apply to many services billed under the OPSS and are based on coding conventions defined in:

- The American Medical Association's (AMA's) CPT manual;
- National and local policies and edits;
- Coding guidelines developed by national societies;
- Analysis of standard medical and surgical practices; and
- A review of current coding practices.

Reinstatement of Drug Administration CCI Edits

CMS suspended application of the CCI edits for OPSS drug administration codes for a brief period to allow hospitals sufficient time to incorporate a series of coding changes that were being implemented under the OPSS into their systems. However, the drug administration CCI edits support correct coding, and they are appropriate for the coding of hospital outpatient services.

Therefore, CMS is reinstating the drug administration CCI edits in April 2006.

As with other CCI edits that will be implemented beginning in April 2006 (OCE CCI version 12.0), the applicable drug administration edits will be posted on the CMS website at <http://www.cms.gov/> shortly before they are activated.

CMS provides a list of National CCI edits for Hospital OPSS at <http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html/NationalCorrectCodInitEd/NCCIEHOPSS/list.asp#TopOfPage> on the CMS website.

Hospitals can refer to the *CCI Coding Manual for Medicare Services*, posted on the CMS website

[\(http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html/](http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html/)

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[NationalCorrectCodInitEd](#)), for a discussion of CCI principles relating to drug administration services.

In addition, hospitals may want to review the CCI edits implemented by Medicare Carriers in January 2006 for more information, as OPPS edits are implemented one calendar quarter behind Carrier edits. However, it is important to note that specific CCI edits in the OCE may differ from edits used by carriers, both with respect to whether a modifier is allowed with a specific code pair and to whether certain edits are actually incorporated in the OCE.

Please note that when an OPPS claim triggers a CCI edit, the entire claim WILL NOT be rejected or returned; only the line item will be rejected.

CCI edits identify a pair of codes where the second code should not be payable with the first code unless an edit permits use of a modifier. The CCI edits may not allow payment of the second code (likely a drug administration code), when reported with the first code in the edit pair.

The claim will continue to process to payment for the first code. Hospitals may want to review their use of applicable modifiers to ensure that services that are appropriate for separate payment are properly coded.

CMS has posted a series of drug administration questions and answers (Q and As) (CY 2006 OPPS Drug Administration [PDF, 25KB] at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/downloads/OPPSGuidance.pdf> on the CMS website, which includes links to the CCI portion of the CMS web site. Information about the CCI can also be accessed from <http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html/NationalCorrectCodInitEd/NCCIEP/list.asp> on the CMS website.

If, after reading the posted information, hospitals continue to have questions about the CCI edit process, or specific hospital outpatient billing questions, they should contact the Medical Director at their local FI. Contact information can be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

The contractor Medical Directors are in the best position to answer provider questions accurately and in a timely manner, taking into account both local and national policies. Hospitals should direct questions about specific CCI edits to the National Correct Coding Initiative at the address listed on the CCI portion of the CMS website.

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Drugs and Biologicals

Drugs and Biologicals with Payment Rates Based on Average Sales Price (ASP) Effective April 1, 2006

The CY 2006 OPPS final rule (70 FR 68643¹), p. 68643, stated that payments for drugs and biologicals based on average sale prices (ASPs) will be updated on a quarterly basis as later quarter ASP submissions become available.

In cases where adjustments to payment rates are necessary, CMS will incorporate changes to the payment rates in the April 2006 release of the OPPS PRICER. CMS is not publishing the updated payment rates in this program instruction implementing the April 2006 update of the OPPS.

However, the updated payment rates effective April 1, 2006, can be found in the April 2006 update of the OPPS Addendum A and Addendum B at http://www.cms.gov/hospitaloutpatientpps/downloads/adda_april06.zip and http://www.cms.gov/HospitalOutpatientPPS/Downloads/addb_april06.zip on the CMS website.

Updated Payment Rate for HCPCS C9129 Effective July 1, 2005 through September 30, 2005

The payment rate for the drug listed below was incorrect in the October 2005 OPPS PRICER.

The corrected payment rate was installed in the January 2006 OPPS PRICER, effective for services furnished on July 1, 2005, through implementation of the October 2005 update.

HCPCS	APC	Short Description	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
C9129	9129	Inj clofarabine	\$116.83	\$23.37

Updated Payment Rates for Certain Drugs and Biologicals Effective October 1, 2005 through December 31, 2005

The payment rates for the drugs and biologicals listed below were incorrect in the October 2005 OPPS PRICER.

The corrected payment rates were installed in the January 2006 OPPS PRICER, effective for services furnished on October 1, 2005 through implementation of the January 2006 update.

¹ 70 FR 68643 can be found at http://www.access.gpo.gov/su_docs/fedreg/a051110c.html

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HCPCS	APC	Short Description	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
C9129	9129	Inj clofarabine	\$116.87	\$23.37
C9212	9212	Inj, alefacept, IM	\$398.34	\$79.67
J9216	0838	Interferon gamma 1-b inj	\$272.44	\$54.49
Q4079	9126	Injection, Natalizumab, 1 MG	\$6.39	\$1.28

Newly-Approved Drugs Eligible for Pass-Through Status

The following drugs have been designated as eligible for pass-through status under the OPSS effective April 1, 2006. Payment rates for these items can be found in the April 2006 update of OPSS Addendum A and Addendum B at http://www.cms.gov/hospitaloutpatientpps/downloads/adda_april06.zip and http://www.cms.gov/HospitalOutpatientPPS/Downloads/addb_april06.zip on the CMS website.

HCPCS	APC	SI	Long Description
C9227	9227	G	Injection, micafungin sodium, per 1 mg
C9228	9228	G	Injection, tigecycline, per 1 mg

Correct Reporting of Units for Drugs

Hospitals and providers are reminded to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the full HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS descriptor.

For example, if the description for the drug code is 50 mg but 200 mg of the drug was administered to the patient, the units billed should be four. Providers and hospitals should not bill the units based on the way the drug is packaged, stored, or stocked. That is, if the HCPCS descriptor for the drug code specifies one mg, and a 10 mg vial of the drug was administered to the patient, bill 10 units, even though only one vial was administered.

HCPCS short descriptors are limited to 28 characters, which include spaces, so short descriptors do not always capture the complete description of the drug. Therefore, before submitting Medicare claims for drugs and biologicals, it is extremely important to review the complete long descriptors for the applicable HCPCS codes.

The full descriptors for the Level II HCPCS codes can be found in the latest code books or from the latest Level II HCPCS file, which is available for downloading from

<http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/index.html/HCPCSReleaseCodeSets/ANHCPCS/list.asp#TopOfPage> on the CMS website.

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Additional Information

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R896CP.pdf> on the CMS website.

If you have any questions, please contact your intermediary at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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