



**News Flash** – The revised *Sole Community Hospital Fact Sheet* (March 2007), which provides information about Sole Community Hospital classification and payments, is now available in print format from the Centers for Medicare & Medicaid Services Medicare Learning Network. To place your order, visit <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html>, scroll down to the “MLN Product Ordering Page.”

MLN Matters Number: MM5718

Related Change Request (CR) #: 5718

Related CR Release Date: September 14, 2007

Effective Date: October 1, 2007

Related CR Transmittal #: R1336CP

Implementation Date: October 1, 2007

**Note:** This article was updated on September 20, 2012, to reflect current Web addresses. All other information remains the same.

## October 2007 Update of the Hospital Outpatient Prospective Payment System (OPPS): Summary of Payment Policy Changes

### Provider Types Affected

Providers submitting claims to Medicare contractors (fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), and/or Medicare Administrative Contractors (A/B MACs)) for outpatient services furnished under the OPPS.

### Impact On Providers

This article is based on Change Request (CR) 5718, which describes changes to the OPPS to be implemented in the October 2007 OPPS update. Be sure billing staff are aware of these changes.

### Background

CR 5718 describes changes to, and billing instructions for, various payment policies implemented in the October 2007 OPPS update. The October 2007 Integrated Code Editor (I/OCE) and OPPS PRICER will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification

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(APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in this notification.

October 2007 revisions to I/OCE data files, instructions, and specifications will be provided in Change Request (CR) 5723, "October 2007 Integrated Outpatient Code Editor (I/OCE) Specifications Version 8.3."

Key changes in CR5718 are as follows:

### ***Changes to Procedure to Device Edits***

The effective dates for the previously existing procedure to device edits for the following procedures are changed from January 1, 2007 to October 1, 2005 in the October 2007 I/OCE:

- **19296** - Placement of radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy.
- **19297** - Placement of radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy concurrent with partial mastectomy (List in addition to code for primary procedure)
- **93651** - Intracardiac catheter ablation of arrhythmogenic focus; for treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathways, accessory atrioventricular connection or other atrial foci, singly or in combination.

### ***Correction to the Offset Percentages for APCs 0315 and 0385***

The Centers for Medicare & Medicaid Services (CMS) reduces the payment for selected Ambulatory Payment Classes (APCs) when specified devices are furnished to the hospital without cost or with a full credit for the cost of the device being replaced. The tables that contain the devices and APCs to which the policy applies can be found on the CMS website at

<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Regulations-and-Notices.html> under supporting documentation for CMS-1506 FC.

There were errors in the entries for two APCs in the table of adjustment percentages and adjustment amounts that were posted before October 1, 2007.

The table containing the corrected amounts is now posted at

<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Regulations-and-Notices.html> under supporting documentation for CMS-1506 FC and is titled: "2007 OPPS Without Cost or With Credit Device Information; corrected 10/01/2007".

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Table 1, below, shows both the incorrect and correct offset percentages and adjustment amounts for APC 0315 (Level II Implantation of Neurostimulator) and APC 0385 (Level I Prosthetic Urological Procedures). The OPPS PRICER for October 2007 contains the corrected amounts with an effective date of January 1, 2007. Your Medicare contractors will adjust claims previously processed for APCs 0315 and 0385 where the modifier FB was reported on the line with the 0315 or 0385, if you bring such claims to their attention.

**Table 1**  
**Offset Percentages and Adjustment Amounts for APCs 0315 and 0385**

APC	0315	0385
APC Group Title	Level II Implantation of Neurostimulator	Level I Prosthetic Urological Procedures
SI	T	S
CY 2007 Payment	\$14,932.81	\$4,868.83
Incorrect CY 2007 Adjustment Percent	76.03%	83.19%
Incorrect CY 2007 Adjustment Amount	\$11,353.42	\$4050.38
Correct CY 2007 Adjustment Percent	83.19%	46.86%
Correct CY 2007 Adjustment Amount	\$12,422.60	\$2,281.53

### ***Billing for Drugs, Biologicals, and Radiopharmaceuticals***

Hospitals are strongly encouraged to report charges for all drugs, biologicals, and radiopharmaceuticals (regardless of whether the items are paid separately or packaged) using the correct HCPCS codes for the items used. It is also very important that hospitals, billing for these products, make certain that the reported units of service of the reported HCPCS code are consistent with the quantity of a drug, biological, or radiopharmaceutical that was used in caring for the patient.

We remind hospitals that under the OPPS, if commercially available products are being mixed together to facilitate their concurrent administration, the hospital should report the quantity of each product (reported by HCPCS code) used in the care of the patient. Alternatively, if the hospital is compounding drugs that are not a mixture of commercially available products, but are a different product that has no applicable HCPCS code, then the hospital should report an appropriate unlisted drug code (J9999 or J3490). In these situations, we remind hospitals that it is not appropriate to bill HCPCS code C9399. HCPCS code C9399, Unclassified drug or biological, is for new drugs and biologicals that are approved by FDA on or after January 1, 2004, for which a HCPCS code has not been assigned.

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### Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective October 1, 2007

In the CY 2007 OPSS final rule, it was stated that payments for separately payable drugs and biologicals based on average sale price (ASP) will be updated on a quarterly basis, as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, changes to the payment rates will be incorporated in the October 2007 release of the OPSS PRICER. The updated payment rates effective October 1, 2007, will be included in the October 2007 update of the OPSS Addendum A and Addendum B, which will be posted at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html> on the CMS website at the end of September.

### Updated Payment Rate for Selected Drugs and Biologicals Effective January 1, 2007 through March 31, 2007

The payment rate for the HCPCS codes in Table 2 below were incorrect in the January 2007 OPSS PRICER. The corrected payment rates are listed in Table 2 are in the October 2007 OPSS PRICER, effective for services furnished on January 1, 2007, through implementation of the April 2007 update. Note that your FI, RHHI, or A/B MAC will adjust claims that you bring to their attention when the claims have dates of service that fall on or after January 1, 2007, but prior to April 1, 2007, contain a HCPCS code listed in Table 2, and were originally processed prior to the installation of the October 2007 OPSS PRICER.

Table 2

#### Updated Payment Rate for HCPCS Code Q3025 Effective January 1, 2007 through March 31, 2007

HCPCS Code	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
Q3025	9022	IM inj interferon beta 1-a	\$115.13	\$23.03
J0152	0917	Adenosine injection	\$69.20	\$13.84
J0215	1633	Alefacept	\$26.28	\$5.26
J0289	0736	Ampho b cholesteryl sulfate	\$16.66	\$3.33
J7342	9054	Metabolically active tissue	\$31.66	\$6.33
J8560	0802	Etoposide oral 50 MG	\$30.53	\$6.11
J9268	0844	Pentostatin injection	\$1,828.98	\$365.80

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**Updated Payment Rates for Selected Drugs and Biologicals  
Effective April 1, 2007 through June 30, 2007**

In the April 2007 OPSS PRICER, the payment rate for APC 9022 was incorrect and the payment rate for APC 0767 was not updated (as the APC 0767 rate did not change from the January rate). The corrected payment rates are listed in Table 3, below, and have been installed in the October 2007 OPSS PRICER, effective for services furnished on April 1, 2007, through June 30, 2007. Note that your FI, RHHI, or A/B MAC will adjust claims that you bring to their attention when the claims have dates of service that fall on or after April 1, 2007, but prior to July 1, 2007; contain at least one of the HCPCS codes listed in Table 3; and were originally processed prior to the installation of the October 2007 OPSS PRICER.

**Table 3  
Updated Payment Rates for Selected Drugs and Biologicals  
Effective April 1, 2007 through June 30, 2007**

HCPCS Code	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
Q3025	9022	IM inj interferon beta 1-a	\$114.50	\$22.90
J1324	0767	Enfuvirtide injection	\$0.38	\$0.08

**New HCPCS Drug Code Separately Payable Under OPSS as of  
October 1, 2007**

The drug shown in Table 4, below, has been designated as eligible for separate payment under the OPSS effective October 1, 2007.

**Table 4  
New Drug Separately Payable under OPSS as of October 1, 2007**

HCPCS Code	APC	SI	Long Descriptor
C9236	9236	K	Injection, eculizumab, 10 mg

The payment rate for this drug can be found in the October 2007 update of OPSS Addendum A and Addendum B which will be posted at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html> on the CMS website at the end of September.

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### **Correct Reporting of Drugs and Biologicals When Used As Implantable Devices**

Hospitals should not bill separately for drug and biological HCPCS codes except when using drugs and biologicals with pass-through status as implantable devices (including as a scaffold or an alternative to human or nonhuman connective tissue or mesh used in a graft) during surgical procedures.

Under the OPPS, hospitals are provided a packaged APC payment for surgical procedures that includes the cost of supportive items, including implantable devices without pass-through status. When using drugs and biologicals as implantable devices during surgical procedures, hospitals may include the charges for these items in their charge for the procedure, report the charge on an uncoded revenue center line or report the charge under a device HCPCS code, if one exists, so these costs would contribute to the future median setting for the associated surgical procedure.

### **Correct Reporting of Units for Drugs**

Hospitals and providers need 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 6 mg, and 6 mg of the drug was administered to the patient, the units billed should be 1. Similarly, 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 4.

Providers and hospitals should bill the units based on the way the drug is administered, not on the way that it is packaged, stored, or stocked. That is, if the HCPCS descriptor for the drug code specifies 1 mg and a 10 mg vial of the drug was administered to the patient, you should bill 10 units, even though only 1 vial was administered. HCPCS short descriptors are limited to 28 characters, including 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.

### ***Coverage Determinations***

The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. Fiscal intermediaries determine whether a drug, device, procedure, or other service meets all program requirements for coverage; such as whether a drug is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

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### *Revisions to Medicare Claims Processing Manual*

CR 5718 also includes several changes to sections in Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)) of the *Medicare Claims Processing Manual*. You may want to review these updated manual sections.

### **Additional Information**

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You can find more information about the October 2007 update of the hospital OPPS summary of payment policy changes by going to CR 5718, located at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1336CP.pdf> on the CMS website. You will find the amended *Medicare Claims Processing Manual*, Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)) as an attachment to that CR.

The list of devices eligible for transitional pass-through payments changes as 1) New device categories are approved for pass-through payment status on an ongoing basis, and 2) Device categories expire from transitional pass-through payment; and their costs are included in APC rates for associated surgical procedures. To view or download the latest complete list of currently payable and previously payable pass-through device categories, refer to <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html> on the CMS website.

Remember that the OCE will return to the provider any claim that reports a HCPCS code for a procedure listed in the table of device edits that does not also report at least one device HCPCS code required for that procedure as listed at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html> on the CMS website. The OCE will also return to the provider claims for which specified devices are billed without the procedure code that is necessary for the device to have therapeutic benefit to the patient. These edits are also listed at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html> on the CMS website. This table shows the effective date for each edit. If the claim is returned to the provider for failure to pass the edits, the hospital will need to modify the claim by either correcting the device code or ensuring that one of the required procedure codes is on the claim before resubmission.

If you have any questions, please contact your FI, RHHI, or A/B MAC 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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