



The *Hospital Outpatient Prospective Payment System Fact Sheet* (revised January 2008), which provides general information about the Hospital Outpatient Prospective Payment System, ambulatory payment classifications, and how payment rates are set, is now available in print format from the Centers for Medicare & Medicaid Services Medicare Learning Network. To place your order, visit <http://go.cms.gov/MLNGenInfo> scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page."

MLN Matters Number: MM5999

Related Change Request (CR) #: 5999

Related CR Release Date: April 8, 2008

Effective Date: April 1, 2008

Related CR Transmittal #: R1487CP

Implementation Date: April 7, 2008

## April 2008 Update of the Hospital Outpatient Prospective Payment System (OPPS)

**Note:** This article was updated on July 12, 2013, to reflect current Web addresses. All other information remains unchanged.

### Provider Types Affected

Providers and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for services paid under the OPPS provided to Medicare beneficiaries.

### Provider Action Needed

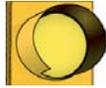


#### STOP – Impact to You

This article is based on Change Request (CR) 5999 which describes changes to, and billing instructions for various payment policies implemented in the April 2008 OPPS update.

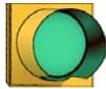
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**CAUTION – What You Need to Know**

CR 5999 announces that the April 2008 Integrated Code Editor (I/OCE) and OPSS PRICER will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions. The specific I/OCE updates for April 2008 are in CR5969.



**GO – What You Need to Do**

See the Background and Additional Information Sections of this article for further details regarding these changes.

## Background

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Change Request (CR) 5999 describes changes to, and billing instructions for various payment policies implemented in the April 2008 OPSS update. The April 2008 Integrated Code Editor (I/OCE) and OPSS 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.

April 2008 revisions to I/OCE data files, instructions, and specifications are provided in Change Request (CR) 5969, "April 2008 Integrated Outpatient Code Editor (I/OCE) Specifications Version 9.1". A related MLN Matters article is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM5969.pdf> on the Centers for Medicare & Medicaid Services (CMS) website. The Key OPSS changes are as follows:

### ***1. Changes to Procedure to Device Edits for April 2008***

Procedures to device edits require that when a particular procedural HCPCS code is billed, the claim must also contain an appropriate device code. Failure to pass these edits will result in the claim being returned to the provider. CMS deleted the procedure to device edits for Current Procedural Terminology (CPT) code 36815, retroactive to their original implementation date of 10/1/2005. The complete list of updated edits can be found under downloads at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html> on the CMS website.

### ***2. Modification of Methodology for Calculation of Hospital Overall Cost-to-Charge Ratio (CCR) for Hospitals that Have Nursing and Paramedical Education Programs***

CMS is updating Section 10.11.8 of the Medicare Claims Processing Manual, Chapter 4, to further refine the methodology of the calculation of the hospital overall CCR for hospitals

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that have nursing and paramedical education programs. Specifically, the instructions for calculating the CCR for cost center 6200 (non-distinct unit observation beds) are being modified. This is a prospective change that is effective April 1, 2008. It is unnecessary to retroactively re-calculate CCRs that are affected by CR 5999.

### ***3. 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 of great importance 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 the care of the patient.

CMS reminds hospitals that under the OPPI, 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, CMS reminds 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.

#### **a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective April 1, 2008**

In the CY 2008 OPPI final rule, it was stated that payments for separately payable 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 based on the most recent ASP submissions, we will incorporate changes to the payment rates in the April 2008 release of the OPPI PRICER. The updated payment rates effective April 1, 2008, will be included in the April 2008 update of the OPPI Addendum A and Addendum B, which will be posted on the CMS Web site at the end of March.

#### **b. Drugs and Biologicals with OPPI Pass-Through Status Effective April 1, 2008**

Four drugs have been granted OPPI pass-through status effective April 1, 2008. These drugs, their descriptors and APC assignments are identified in Table 1 below.

**Table 1 - Drugs and Biologicals with OPPI Pass-Through Status Effective April 1, 2008**

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 4/1/08
C9241	Injection, doripenem, 10 mg	9241	G

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HCPCS Code	Long Descriptor	APC	Status Indicator Effective 4/1/08
C9240	Injection, ixabepilone, 1 mg	9240	G
C9238	Injection, levetiracetam, 10 mg	9238	G
J9226	Histrelin implant (Supprelin La), 50 mg	1142	G

### c. New HCPCS Codes for Drugs and Biologicals Effective April 1, 2008

Three new HCPCS codes have been created effective April 1, 2008. These new HCPCS codes, their descriptors, OPPS status indicators and APC assignments are listed in Table 2 below.

Table 2 - New HCPCS Codes for Drugs and Biologicals Effective April 1, 2008

HCPCS Code	Long Descriptor	APC	Status Indicator
Q4096	Injection, Von Willebrand factor complex, human, ristocetin cofactor (not otherwise specified), per i.u. VWF:RCO	1213	K
Q4097	Injection, immune globulin (Privigen), intravenous, non-lyophilized (e.g., liquid), 500 mg	1214	K
Q4098	Injection, iron dextran, 50 mg	1215	K

### d. Revised Long and Short HCPCS Code Descriptors for Cardiac Echocardiography Services:

- **Cardiac Echocardiography With Contrast**

In the January 2008 Update to the OPPS (CR5912, dated January 18, 2008; see related MLN Matters article at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM5912.pdf> on the CMS website), CMS listed eight new C-codes in Table 14 of CR5912 for cardiac echocardiography with contrast services. To ensure appropriate reporting of these services, CMS revised the short and long descriptors for C8921 through C8928, which are reflected in Table 3 below, to appropriately reflect those services that either use contrast or are performed without contrast followed by with contrast. Hospitals are reminded that these codes should be reported for echocardiograms with contrast, and hospitals are advised to report the appropriate units of the HCPCS codes for the contrast agents used in the performance of the echocardiograms. The contrast HCPCS Q-codes associated with these services should be reported separately.

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**Table 3 - Revised Long and Short HCPCS Code Descriptors for Cardiac Echocardiography Services**

HCPCS	Revised Short Descriptor	Revised Long Descriptor
C8921	TTE w or w/o fol w/cont, com	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; complete
C8922	TTE w or w/o fol w/cont, f/u	Transthoracic echocardiography with contrast, or without contrast followed by with contrast; follow-up or limited study
C8923	2D TTE w or w/o fol w/con,co	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2d) with or without m-mode recording; complete
C8924	2D TTE w or w/o fol w/con,fu	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, material real-time with image documentation (2d) with or without m-mode recording; follow-up or limited study
C8925	2D TEE w or w/o fol w/con,in	Transesophageal echocardiography (tee) with contrast, or without contrast followed by with contrast, real time with image documentation (2d) (with or without m-mode recording); including probe placement, image acquisition, interpretation and report
C8926	TEE w or w/o fol w/cont,cong	Transesophageal echocardiography (tee) with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report
C8927	TEE w or w/o fol w/cont, mon	Transesophageal echocardiography (tee) with contrast, or without contrast followed by with contrast, for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis
C8928	TEE w or w/o fol w/con,stres	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2d), with or without m-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report

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- **Cardiac Echocardiography Without Contrast**

Hospitals are reminded to bill for echocardiograms without contrast in accordance with the CPT code descriptors and guidelines associated with the applicable Level I CPT code(s) (93303-93350).

**e. Recognition of Multiple HCPCS Codes for Drugs**

Prior to January 1, 2008, the OPSS generally recognized only the lowest available administrative dose of a drug if multiple HCPCS codes existed for the drug; for the remainder of the doses, the OPSS assigned a status indicator "B" indicating that another code existed for OPSS purposes. For example, if drug X has 2 HCPCS codes, the first for a 1 ml dose and a second for a 5 ml dose, the OPSS would assign a payable status indicator to the 1 ml dose and status indicator "B" to the 5 ml dose. Hospitals then were required to bill the appropriate number of units for the 1 ml dose in order to receive payment under the OPSS. However, beginning January 1, 2008, the OPSS has recognized each HCPCS code for a Part B drug, regardless of the units identified in the drug descriptor. Hospitals may choose to report multiple HCPCS codes for a single drug, or to continue billing the HCPCS code with the lowest dosage descriptor available.

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

Hospitals are not to bill separately for drug and biological HCPCS codes, with the exception of drugs and biologicals with pass-through status, when using these items 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 OPSS, 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 during surgical procedures as implantable devices, 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 appropriately contribute to the future median setting for the associated surgical procedure.

**g. 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 6 mg, and 6 mg of the drug was administered to the patient, the units billed should be 1. As another 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 4. 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 1 mg and a 10 mg vial of the drug was administered to the patient, 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

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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.

#### ***4. HCPCS Code G0377***

HCPCS code G0377 (Administration of vaccine for Part D drug) that was in effect for 2007 is discontinued for CY 2008. The April 2008 OCE will implement this change effective January 1, 2008. Hospitals should no longer be reporting this service under OPSS, as this service is covered under the Part D benefit beginning in 2008.

#### ***5. Use of HCPCS Modifiers***

CMS updated the Medicare Claims Processing Manual, Chapter 4, Section 20.6 to reflect the addition of HCPCS modifiers –FB and –FC effective, January 1, 2007, and January 1, 2008, respectively. CMS added Section 20.6.10, which includes the definition of the modifier -FC (“Partial credit received for replaced device”). This manual revision is attached to CR5999. OPSS hospitals must report the -FC modifier for cases in which the hospital receives a partial credit of 50 percent or more of the cost of a new replacement device under warranty, recall, or field action. The hospital must append the -FC modifier to the procedure code (not the device code) that reports the services provided to replace the device.

#### ***6. Clarification of HCPCS Code to Revenue Code Reporting***

CMS updated the Medicare Claims Processing Manual, Chapter 4, Section 20.5 to reflect that, generally, CMS does not instruct hospitals on the assignment of HCPCS codes to revenue codes for services provided under OPSS since hospitals’ assignments of costs vary. Where explicit instructions are not provided, providers should report their charges under the revenue code that will result in the charges being assigned to the same cost center to which the cost of those services are assigned in the cost report. Previous language providing guidance on HCPCS code and revenue code billing was deleted.

#### ***7. Clarification of Manual Instructions Regarding Billing and Payment for Blood and Blood Products under the OPSS***

CMS updated the Medicare Claims Processing Manual, Chapter 4, Section 231 to provide important clarifications regarding billing for blood and blood products. In Section 231.2, CMS specifies that the requirement that the same line item date of service, the same number of units, the same HCPCS code, and HCPCS modifier BL must be reported on **both** lines, applies to all OPSS providers that transfuse blood. CMS also clarifies that, in order to ensure correct application of the Medicare blood deductible, providers should report charges for whole units of packed red cells using Revenue Code 381 (Packed red cells), and should report charges for whole units of whole blood using Revenue Code 382 (Whole blood). Revenue Codes 381 and 382 should be used only to report charges for packed red cells and whole blood, respectively. The blood coding requirements discussed in Section 231.2 do not apply to blood and blood products carrying only a processing and

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storage fee; when billing only for blood processing and storage, OPPS providers should follow the coding requirements outlined in Section 231.1. Revenue Code 380 is not a valid revenue code for Medicare billing.

In a revised Section 231.4, Chapter 4 of the Medicare Claims Processing Manual, CMS clarifies that providers should bill split units of packed red cells and whole blood using Revenue Code 389 (Other blood), and should not use Revenue Codes 381 (Packed red cells) or 382 (Whole blood). Providers should bill split units of other blood products using the applicable revenue codes for the blood product type, such as 383 (Plasma) or 384 (Platelets), rather than 389. Reporting revenue codes according to these specifications will ensure the Medicare beneficiary's blood deductible is applied correctly. In revised Section 231.6, CMS provides a chart of blood and blood products indicating whether providers should bill separately for freezing and thawing using the available CPT codes.

In revised Section 231.7 of Chapter 4, CMS specifies that where blood or a blood product is split or irradiated specifically with the intent of transfusion to a beneficiary but is not then used, the hospital may bill for the services of splitting or irradiating the unit of blood but may not bill for the HCPCS code for the blood product that was not transfused. The date of service must be the date on which the decision not to use the blood was made and indicated in the patient's medical record. Where the unit of blood is split or irradiated and stored without specific intention to administer it to a Medicare beneficiary at the time of splitting or irradiation and is not subsequently transfused, there is no service to be reported.

All of the revised sections referenced above are attached to CR5999.

### ***8. Outpatient Partial Hospitalization Program Services***

With CR5999, CMS is updating the Medicare Claims Processing Manual, Chapter 4, Sections 260.1 and 260.1.1 to reflect the current policies for Outpatient Partial Hospitalization Program Services. Once again, the revised manual section is attached to CR5999.

### ***9. 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. FIs and Medicare Administrative Contractors determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, FIs determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

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## Additional Information

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The official instruction, CR 5999, issued to your FI and A/B MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1487CP.pdf> on the CMS website.

If you have any questions, please contact your FI 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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