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MMA - January 2005 Update of the Hospital Outpatient Prospective Payment System (OPPS): Summary of Payment Policy Changes

Note: This article was updated on May 9, 2013, to reflect current Web addresses. All other information remains unchanged.

Provider Types Affected

Hospitals and other providers billing Medicare fiscal intermediaries (FIs) for claims paid under the OPPS

Provider Action Needed

Physicians, providers and suppliers should note that this article describes Change Request (CR) 3632 which covers changes to, and billing instructions for, various payment policies implemented by Medicare in the January 2005 OPPS update.

Background

The policies implemented in CR 3632 were discussed in the 2005 OPPS final rule, which was published in the Federal Register (FR) on November 15, 2004 (Federal Register, Volume 69, page 65682), and unless otherwise noted, all changes addressed in CR 3632 are effective for services furnished on or after January 1, 2005.

The January 2005 OPPS Outpatient Code Editor (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 CR 3632.

The following includes information relevant to the January 2005 instructions:

- Changes to the OPPS OCE data files, the OPPS PRICER logic, and payment policy for diagnostic mammography are provided in CR 3586, "January 2005 Update of the Hospital Outpatient Prospective Payment System (OPPS): Summary of OPPS Outpatient Code Editor (OCE)

Data Changes and OPPS PRICER Logic Changes; Changes to Payment for Diagnostic Mammography," issued December 3, 2004. For information on this, see MLN Matters article MM3586, which can be found at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/mm3586.pdf on the CMS website.

- Instructions for non-pass-through devices are provided in CR 3606, "January 2005 Update of the Hospital Outpatient Prospective Payment System (OPPS): Billing for Devices that do not have Transitional Pass-Through Status and that are not Classified as New Technology APCs." A MLN Matters article, MM3606, is also available for that CR at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/mm3606.pdf on the CMS website.
- Instructions for Drug administration are provided in CR 3610, "January 2005 Update of the Hospital Outpatient Prospective Payment System (OPPS): Changes to Coding and Payment for Drug Administration." These instructions are discussed in the MLN Matters article at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/mm3610.pdf on the CMS website.
- Revisions to OPPS OCE instructions and specifications are provided in CR 3583, "January 2005 Outpatient Prospective Payment System Code Editor (OPPS OCE) Specifications Version 6.0," issued December 3, 2004. These instructions are covered in MLN Matters article MM3583 at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/mm3583.pdf on the CMS website.

Key changes for the January 2005 update are as follows:

1. Hyperbaric Oxygen Therapy

Hospitals providing hyperbaric oxygen (HBO) therapy should continue to report this service using the following HCPCS code:

- HCPCS Code C1300, *Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval*.

In addition, effective January 1, 2005, the following may be included in calculating the total number of 30-minute intervals billable under HCPCS code C1300:

- Time spent by the patient under 100% oxygen;
- Descent;
- Airbreaks; and
- Ascent.

NOTE: A physician order for a 90-minute HBO treatment typically means that the physician desires that the patient be placed under 100% oxygen for 90 minutes. In order to safely achieve 100% oxygen for 90 minutes, additional time may be needed to provide for the descent, airbreaks, and ascent. Therefore, the total number of billable 30-minute intervals would not be based solely on the amount of time noted on the physician order.

In calculating how many 30-minute intervals to report, hospitals should take into consideration the time spent under pressure during descent, airbreaks, and ascent.

Additional units may be billed for sessions requiring at least 16 minutes of the next 30-minute interval. For example, two units of HCPCS code C1300 should be billed for a session in duration of between 46 and 75 minutes, while three units should be billed for a session in duration of between 76 and 105 minutes. Further, four units of HCPCS code C1300 should be billed for a session in duration of between 106 and 135 minutes.

HBO is typically prescribed for an average of 90 minutes, which hospitals should report using appropriate units of HCPCS code C1300 in order to properly bill for full body HBO therapy. In general, the Centers for Medicare and Medicaid Services (CMS) does not expect that a physician order for 90 minutes of HBO therapy would exceed four billed units of HCPCS code C1300.

Example:

Physician orders and patient receives 90 minutes of therapeutic HBO. Patient requires and receives 10 minutes of descent time, 10 minutes of air breaks, and 10 minutes of ascent time. To bill correctly, hospital should bill 4 units of HCPCS code C1300, reflecting the sum of 90 minutes of therapeutic HBO, 10 minutes of descent time, 10 minutes for airbreaks, and 10 minutes of ascent time.

2. Payment for Brachytherapy Sources

Section 621(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established separate payment for brachytherapy devices consisting of a seed or seeds (or radioactive source), based on the hospital's charges for the source(s), adjusted to cost, effective January 1, 2004 through December 31, 2006.

CR 3154 (Transmittal 132), issued March 30, 2004, provided instructions regarding this change to billing and payment for brachytherapy sources and identified the applicable codes that became effective for this payment as of January 1, 2004.

Table 1 provides a listing of three new codes to be reported for payment of brachytherapy sources under the OPPS.

Table 1: New Brachytherapy Codes

HCPCS Code	Effective Date	SI	APC	Short Descriptor	Long Descriptor
C2634	01/01/05	H	2634	Brachytx source, HA, I-125	Brachytherapy source, high activity, iodine-125, per source
C2635	01/01/05	H	2635	Brachytx source, HA, P-103	Brachytherapy source, high activity, paladium-103, per source
C2636	01/01/05	H	2636	Brachytx linear source, P-103	Brachytherapy linear source, paladium-103, per 1 mm

3. New Services

The following new services are assigned for payment under the OPPS:

a. Kyphoplasty

Kyphoplasty is a new surgical procedure intended to treat vertebral compression fractures. The procedure involves percutaneous insertion of an inflatable balloon tamp into a vertebral body to create a void and to partially restore vertebral body height. This is followed by introduction of bone cement under low pressure to fill the cavity in the vertebral body. A single level vertebral kyphoplasty procedure may involve either unilateral or bilateral vertebral body void creation and injection of cement.

Hospitals should bill for kyphoplasty as complete procedures, coding only one unit of the appropriate C-code for each vertebral body treated. In addition to the kyphoplasty C-codes, hospitals may bill for the radiological supervision and interpretation service provided during the kyphoplasty.

Table 2 provides a listing of two new codes to be reported for kyphoplasty under the OPPS.

Table 2: New Kyphoplasty Codes

HCPCS Code	Effective Date	SI	APC	Short Descriptor	Long Descriptor	Payment Rate	Minimum Unadjusted Copayment
C9718	01/01/05	T	0051	Kyphoplasty, first vertebra	Kyphoplasty, one vertebral body, unilateral or bilateral injection	$2043.45	$408.69
C9719	01/01/05	T	0051	Kyphoplasty, each additional	Kyphoplasty, one vertebral body, unilateral or bilateral injection, each additional vertebral body	$2043.45	$408.69

b. High-Energy (> 0.22MJ/MM2) Extracorporeal Shock Wave (ESW) Treatment

The following new service is assigned to a new technology APC for payment under the OPPS.

Table 3: New Code for High-Energy ESW Treatment

HCPCS Code	Effective Date	SI	APC	Short Descriptor	Long Descriptor	Payment Rate	Minimum Unadjusted Copayment
C9720	01/01/05	T	1547	HE ESW tx, tennis elbow	High-energy (greater than 0.22MJ/MM2) extracorporeal shock wave (ESW) treatment for chronic lateral epicondylitis (tennis elbow	$850.00	$170.00
C9721	01/01/05	T	1547	HE ESW tx, plantar fasciitis	High-energy (greater than 0.22MJ/MM2) extracorporeal shock wave (ESW) treatment for chronic plantar fasciitis	$850.00	$170.00

c. Stereoscopic Kv-x-ray Imaging with Infrared Tracking for Localization of Target Volume

The following new service is assigned to a new technology APC for payment under the OPPS. Do not report C9722 in conjunction with G0173, G0243, G0251, G0339, or G0340.

Table 4: New Code for Stereoscopic KV X-Ray Imaging

HCPCS Code	Effective Date	SI	APC	Short Descriptor	Long Descriptor	Payment Rate	Minimum Unadjusted Copayment
C9722	01/01/05	S	1502	KV imaging w/IR tracking	Stereoscopic KV x-ray imaging with infrared tracking for localization of target volume	$75.00	$15.00

4. Billing for Observation Services (APC 0339)

In the 2005 OPPS final rule, CMS made several policy changes related to separate payment of APC 0339 for observation services provided in the hospital outpatient department, in order to simplify billing for hospitals. The changes are effective for services provided on or after January 1, 2005.

a. The descriptor for HCPCS code G0244 is changed to read: *Observation care provided by a facility to a patient with CHF, chest pain or asthma, minimum 8 hours*.

The new descriptor clarifies that separate payment will be made for observation services only when a minimum of 8 hours of care have been provided to the beneficiary. Hospitals should report the number of hours the outpatient is in observation status.

b. To receive separate payment for HCPCS code G0244, hospitals are required to report a qualifying ICD-9-CM diagnosis code for 1) Congestive Heart Failure (CHF), 2) chest pain or 3) asthma as one of the following:

- Admitting Diagnosis/Reason for Patient Visit, or
- Principal Diagnosis.

The list of ICD-9-CM codes is published in the 2005 OPPS final rule. The code must be reported in the Admitting Diagnosis/Reason for Patient Visit field (form locator 76 or its electronic equivalent) or the Principal Diagnosis field (form locator 67 or its electronic equivalent) to qualify for separate payment for observation services.

c. Observation time begins at the clock time documented in the patient's medical record, which coincides with the time the patient is placed in a bed for the purpose of initiating observation care in accordance with a physician's order.

d. Observation time ends either when the patient is discharged from the hospital or is admitted as an inpatient. The time when a patient is "discharged" from observation status is the clock time when all clinical or medical interventions have been completed, including any necessary follow-up care furnished by hospital staff and physicians that may take place after a physician has ordered that the patient be released or admitted as an inpatient.

However, observation care does not include time spent by the patient in the hospital subsequent to the conclusion of therapeutic, clinical, or medical interventions, such as time spent waiting for transportation to go home.

5. Billing for Drugs, Biologicals, and Radiopharmaceuticals

a. New Dosage Descriptors for Certain Drugs and Biologicals

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 unit of service is consistent with the quantity of a drug, biological, or radiopharmaceutical that was actually administered to the patient.

For 2005, several HCPCS codes for drugs and biologicals have undergone changes in their HCPCS descriptors. **Hospitals should be reminded that they should bill for units of service consistent with the dosages contained in the new long descriptors.**

The affected HCPCS codes are listed in the Table 5.

Table 5: New Dosage Descriptors for Certain Drugs and Biologicals

Old HCPCS	Old Long Descriptor	New HCPCS	New Long Descriptor
C9109	Injection, tirofiban hydrochloride, 6.25 mg	J3246	Injection, tirofiban HCL, 0.25 mg
C9125	Injection, risperidone, per 12.5 mg	J2794	Injection, risperidone, long acting, 0.5 mg
C9207	Injection, bortezomib, per 3.5 mg	J9041	Injection, bortezomib, 0.1 mg
C9209	Injection, laronidase, per 2.9 mg	J1931	Injection, laronidase, 0.1 mg
C9210	Injection, palonosetron hydrochloride, per 250 mcg	J2469	Injection, palonosetron HCL, 25 mcg
J3245	Injection, tirofiban hydrochloride, 12.5 mg	J3246	Injection, tirofiban HCL, 0.25 mg
J3395	Injection, verteporfin, 15 mg	J3396	Injection, verteporfin, 0.1 mg

Note: Hospital should be aware that effective January 1, 2005 radiopharmaceutical agents will be treated as drugs; therefore, these agents will no longer be eligible for outlier payments under OPPS.

b. Updated Payment Rates for Certain Drugs and Biologicals, including Orphan Drugs, Reflecting Third Quarter 2004 Average Sales Price (ASP) Submissions

In the 2005 OPPS final rule (Federal Register, Volume 69, page 65777), it was 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.

Effective January 1, 2005, payment rates for several drugs and biologicals have changed from the values published in the 2005 OPPS final rule as a result of the new ASP calculations (based on sales price submissions from the third quarter of 2004). The affected drugs and biologicals, with changes in their payment rates, are listed below in Table 6.

Table 6 - Updated Payment Rates for Certain Drugs and Biologicals

HCPCS	APC	Short Descriptor	Payment Rate	Copayment
C9123	9123	Transcyte, per 247 sq cm	$706.16	$141.23
C9205	9205	Oxaliplatin	$82.41	$16.48
C9212	9212	Inj, alefacept, IM	$399.75	$79.95
C9218	9218	Injection, azacitidine	$4.19	$0.84
C9220	9220	Sodium hyaluronate	$215.72	$43.14
J0128	9216	Abarelix injection	$68.62	$13.72
J0135	1083	Adalimumab injection	$288.78	$57.76
J0180	9208	Agalsidase beta injection	$121.12	$24.22
J0256	0901	Alpha 1 proteinase inhibitor	$3.28	$0.66
J0595	0703	Butorphanol tartrate 1 mg	$4.74	$0.95
J1457	1085	Gallium nitrate injection	$1.25	$0.25
J2185	0729	Meropenem	$3.40	$0.68
J2280	1046	Inj, moxifloxacin 100 mg	$3.77	$0.75
J2357	9300	Omalizumab injection	$15.32	$3.06
J2469	9210	Palonosetron HCl	$18.22	$3.64
J2783	0738	Rasburicase	$107.01	$21.40
J2794	9125	Risperidone, long acting	$4.60	$0.92
J3240	9108	Thyrotropin injection	$699.60	$139.92
J3411	1049	Thiamine hcl 100 mg	$0.58	$0.12
J3415	1050	Pyridoxine hcl 100 mg	$2.36	$0.47
J3465	1052	Injection, voriconazole	$4.55	$0.91
J3486	9204	Ziprasidone mesylate	$18.74	$3.75
J7308	7308	Aminolevulinic acid hcl top	$87.65	$17.53
J7518	9219	Mycophenolic acid	$2.42	$0.48
J7674	0867	Methacholine chloride, neb	$0.41	$0.08
J9035	9214	Bevacizumab injection	$57.08	$11.42
J9041	9207	Bortezomib injection	$28.38	$5.68
J9055	9215	Cetuximab injection	$49.64	$9.93
J9216	0838	Interferon gamma 1-b inj	$265.67	$53.13
J9300	9004	Gemtuzumab ozogamicin	$2,203.67	$440.73
Q4076	1070	Dopamine hcl, 40 mg	$0.72	$0.14

c. Billing for Radiopharmaceuticals: Use of Revenue Codes 343 and 344

The following Revenue Codes were added to the OPPS OCE as valid revenue codes in the October 2004 update of the OPPS (CR 3420, issued August 27, 2004).

- Revenue code 343, Diagnostic Radiopharmaceuticals, and
- Revenue code 344, Therapeutic Radiopharmaceuticals

Hospitals are encouraged to use these revenue codes when billing for radiopharmaceuticals.

d. Payment for Drugs and Biologicals Recently Approved by the FDA

CR 3287 (Transmittal 188), issued May 28, 2004, explains how hospitals may report new drugs and biologicals after Food and Drug Administration (FDA) approval but before assignment of product-specific HCPCS codes.

Beginning in 2004, the MMA requires that payment for new drugs and biologicals (after FDA approval but before assignment of product-specific HCPCS codes) be equal to 95 percent of AWP. The following drug was approved by the FDA on November 23, 2004. CMS is assigning the following product-specific HCPCS code for billing of *Injection, Natalizumab, per 5 mg*:

Table 7: New Code for Injection, Natalizumab, per 5 mg

HCPCS	SI	APC	Short Descriptor	Long Descriptor	Payment Rate	Minimum Unadjusted Copayment	Effective Date of Payment Rate
C9126	K	9126	Injection, natalizumab	Injection, natalizumab, per 5 mg	$30.13	$6.03	11/23/04

For claims submitted prior to implementation of the January 2005 OPPS OCE, hospitals may bill for natalizumab injections using the following HCPCS code in accordance with CR 3287:

- HCPCS Code C9399, *Unclassified Drug or Biological*.

For claims submitted on or after implementation of the January 2005 OPPS OCE, hospitals should bill for natalizumab injections using the following product-specific HCPCS code:

- HCPCS Code C9126, *Injection, natalizumab*.

Note: Fiscal intermediaries (FIs) will return claims for natalizumab billed with C9399 that are submitted after installation of the January 2005 OPPS update.

e. Status Indicator Assignment for Injection, azacitidine

HCPCS C9218, *Injection, azacitidine*, and its associated APC, 9218, were inadvertently:

- Assigned status indicator "G" in Addendum A and Addendum B in the 2005 OPPS final rule, and
- Included in Table 23, "List of Drugs and Biologicals with Pass-Through Status in CY 2005."

As stated in the preamble of the November 15, 2004 Federal Register final rule with comment period, effective January 1, 2005, HCPCS C9218:

- Is assigned status indicator K instead of status indicator G, and

- Will be paid as a single indication orphan drug rather than as a drug with pass-through status (Federal Register, Volume 69, page 65808).

6. Endometrial Cryoablation with Ultrasonic Guidance

For services furnished on or after January 1, 2005 to report endometrial cryoablation with ultrasonic guidance:

- Use CPT code 58356, and
- Discontinue reporting CPT code 0009T.

7. Determining Payment for Carrier-Priced Items and Services that are Assigned Status Indicator "A" under the OPPS (Services furnished to hospital outpatients that are paid under a fee schedule or payment system other than OPPS)

In order to ensure that services that are assigned Status Indicator "A" under the OPPS are being paid appropriately, your FI will follow the procedures defined in the Medicare Claims Processing Manual (Pub. 100-04), Chapter 23 (*Fee Schedule Administration and Coding Requirements)*, Section 40.4.1 (*Carriers Forward HCPCS Gap Fill Amounts to Fiscal Intermediaries)*, and Section 50 (*Fee Schedules Used by All Intermediaries and Regional Home Health Intermediaries (RHHIs))*.

8. Placement of Needle for Intraosseous Infusion (36680)

In the 2005 OPPS Final Rule, CMS inadvertently mapped CPT code 36680 *Placement of Needle for Intraosseous Infusion* to APC 120, which is an infusion APC.

CPT 36680 is not a code for infusion; it is a code for placement of a needle.

Therefore, CMS has corrected the APC assignment for CPT 36680, effective January 1, 2005, to APC 0002, *Level I Fine Needle Biopsy/Aspiration*.

9. Therapeutic Apheresis

Since non-facility practice expense Relative Value Units (RVUs) were established for CPT codes 36515 and 36516 in the 2005 update of the Medicare Physician Fee Schedule, published in the November 15, 2004 Federal Register, questions have been raised regarding how hospitals should report certain therapeutic apheresis services. In every case, hospitals should report the codes that most accurately describe the service that is furnished.

When using CPT code 36515 to report *extracorporeal immunoadsorption treatment and plasma reinfusion with a protein A column* for indications such as 1) rheumatoid arthritis and 2) idiopathic thrombocytopenic purpura, hospitals may:

- Include the charge for the protein A column with the charge for CPT 36515 or
- Include the charge using an appropriate supply revenue code.

Similarly, when using CPT code 36516 to report *extracorporeal selective adsorption or selective filtration and plasma reinfusion,* for indications such as familial hypercholesterolemia, hospitals may:

- Bill supply charges with the charge for CPT code 36516 or
- Bill supply charges using an appropriate supply revenue code.

Important Reminder Regarding Coverage Determinations

The fact that a HCPCS code and payment rate under the OPPS is assigned (for a drug, device, procedure, or service) does not imply coverage by the Medicare program. It only indicates how the product, procedure, or service may be paid if covered by the program.

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

Additional Information

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed by going to *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R423CP.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.