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MLN Matters Number: MM5121 | Related Change Request (CR) #: 5121

Related CR Release Date: May 30, 2006 | Effective Date: July 1, 2006

Related CR Transmittal #: R970CP | Implementation Date: July 3, 2006

Note: This article was updated on November 8, 2012, to reflect current Web addresses. All other information remains unchanged.

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

Provider Types Affected

Providers submitting claims to Medicare fiscal intermediaries (FIs) and/or regional home health intermediaries (RHHIs) for outpatient services furnished under the OPPS.

Impact on Providers

This article is based on Change Request (CR) 5121, which describes changes to the OPPS to be implemented in the July 2006 OPPS update.

Background

Change Request (CR) 5121 describes changes to the hospital Outpatient Prospective Payment System (OPPS) to be implemented in the July 2006 OPPS update. The July 2006 OPPS Outpatient Code Editor (OCE) and OPPS PRICER reflects the Healthcare Common Procedure Coding System (HCPCS) and Ambulatory Payment Classification (APC) additions, changes, and deletions identified in CR 5121.

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In addition, the July 2006 revisions to the OPPS OCE data files, instructions, and specifications are provided in CR 5065, "July 2006 Outpatient Prospective Payment System Code Editor (OPPS OCE) Specifications Version 7.2." CR 5065 can be found at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R970CP.pdf on the CMS website.

Key changes in CR5121 are as follows:

1. Category III CPT Codes

The American Medical Association (AMA) releases Category III Current Procedural Terminology (CPT) codes in:

- January, for implementation beginning the following July; and
- July, for implementation beginning the following January.

Prior to CY 2006 CMS implemented new Category III CPT codes once a year, in January.

As stated in the November 10, 2005 final rule (with comment period (70 FR 68567) for CY 2006; http://www.access.gpo.gov/su_docs/fedreg/a051110c.html), CMS has modified the process for implementing the Category III codes that the AMA releases each January for implementation in July.

Note: Beginning July 1, 2006, the OCE will recognize tracking codes that AMA implements in July, rather than deferring recognition until the following January.

The following seven Category III CPT codes (that the AMA released in January 2006 for implementation in July 2006) will be reportable for services furnished on or after July 1, 2006. The codes, along with their status indicators and Ambulatory Payment Classifications (APCs), are shown in the following table.

Category III CPT Codes Implemented in July 2006

HCPCS Code	Long Descriptor	SI	APC	Payment Rate	Minimum Unadjusted Copayment
0155T	Laparoscopy, surgical, implantation or replacement of gastric stimulation electrodes, lesser curvature (i.e., morbid obesity)	T	0130	$1,896.93	$379.39
0156T	Laparoscopy, surgical, revision or removal of gastric stimulation electrodes, lesser curvature (i.e., morbid obesity)	T	0130	$1,896.93	$379.39
0157T	Laparotomy, implantation or replacement of gastric stimulation electrodes, lesser curvature (i.e., morbid obesity)	C			

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HCPCS Code	Long Descriptor	SI	APC	Payment Rate	Minimum Unadjusted Copayment
0158T	Laparotomy, revision or removal of gastric stimulation electrodes, lesser curvature (i.e., morbid obesity)	C			
0159T	Computer aided detection, including computer algorithm analysis of MRI image data for lesion detection/characterization, pharmacokinetic analysis, with further physician review for interpretation, breast MRI	N			
0160T	Therapeutic repetitive transcranial magnetic stimulation treatment planning	X	0340	$36.52	$7.30
0161T	Therapeutic repetitive transcranial magnetic stimulation treatment delivery and management, per session	X	0340	$36.52	$7.30

2. Replacement of Upgraded Devices with Full Credit for the Replaced Device

Occasionally, recalled or defective devices are replaced with an upgraded device and the cost to the hospital of the upgraded device is greater than the cost of the replaced device. The device manufacturer may give the hospital a credit for the sales price of the device being replaced. The hospital may then have to pay the manufacturer for the difference in the prices of the two devices and hospitals have asked how to bill Medicare for these differences.

The hospital should report the following:

- The HCPCS code for the upgraded device being implanted;
- Condition code 50 denoting "Product Replacement for Known Recall of a Product—Manufacturer or the Food and Drug Administration has identified the product for recall and therefore replacement"; and
- Report the charge for the upgraded replacement device that equals the difference between its usual charge for the replaced device and its usual charge for the upgraded device.

Note: Do not report the FB modifier because the device is not being furnished without cost by the manufacturer.

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3. Drugs and Biologicals

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

The CY2006 OPPS final rule (70 FR 68643; http://www.access.gpo.gov/su_docs/fedreg/a051110c.html) 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 July 2006 release of the OPPS PRICER. The updated payment rates effective July 1, 2006 will be included in the July 2006 update of the OPPS Addendum A and Addendum B, which will be posted at the end of June at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html on the CMS website.

b) Newly-Approved Drugs Eligible for Pass-Through Status

The following drugs have been designated as eligible for pass-through status under the OPPS effective July 1, 2006. Payment rates for these items can be found in the July 2006 update of OPPS Addendum A and Addendum B, which will be posted on the CMS website at the end of June.

HCPCS Code	APC	SI	Long Description
C9229	9229	G	Injection, ibandronate sodium, per 1 mg
C9230	9230	G	Injection, abatacept, per 10 mg

c) Payment for New, Unclassified Drugs or Biologicals Approved by the Food and Drug Administration (FDA) before January 1, 2004, but before Assignment of a Product-Specific Drug/Biological HCPCS Code

CR3287 (Transmittal 188, dated May 28, 2004; http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R188CP.pdf) requires hospitals to report C9399 to bill for new drugs and biologicals that were approved by the FDA on or after January 1, 2004, for which pass-through status had not been approved and a C-code and APC payment are not assigned. Medicare Contractors should not allow payment for any drugs billed using C9399 for which FDA approval was granted before January 1, 2004. Information on approval dates is available at http://www.fda.gov on the Internet.

d) Payment Rates for Tetanus and Diphtheria Vaccine Effective July 1, 2005, through December 31, 2005

The payment rates for these vaccines were not included in the April 2006 OPPS PRICER, but are included in the July 2006 OPPS PRICER. For HCPCS 90714, APC 1634 (Tetanus and diphtheria toxoids (td) absorbed, preservative free, for

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use in individuals 7 years or older, for intramuscular use), the payment rate for this period is $17.81 and the minimum unadjusted copayment is $3.56.

Medicare FIs/RHHIs will adjust as appropriate claims you bring to their attention that meet all of the following conditions:

- Were incorrectly paid for services furnished on or after July 1, 2005 through December 31, 2005;
- Were processed by the FI/RHHI before the installation of the July 2006 OPPS PRICER with updated ASP payment rates; and
- Contain HCPCS 90714

e) 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.

Note: Providers and hospitals should not bill the units based on the way the drug is packaged, stored, or stocked. 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 one vial was administered.

HCPCS short descriptors are limited to 28 characters (which includes 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 the CMS web site at http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/index.html on the CMS website.

Note: Providers are reminded to check HCPCS descriptors for any changes to the units when HCPCS definitions or codes are changed.

4. Overpayment of Certain Blood Products

Effective for dates of service on or after July 1, 2005, providers should report charges for processing/storage of blood (revenue code 39X) when they also report a charge for blood or blood products under revenue code 38X. PRICER determines a ratio of the total 38x charges to the combined 38x-39x charges.

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This allows PRICER to pay each line according to the respective blood portion so that only one APC payment is made per unit. CMS recently discovered that the OPPS PRICER is only computing this ratio for blood products to which the blood deductible applies, and not for all blood products.

This means that PRICER is overpaying what it should on revenue code 38X-39X line pairs for HCPCS codes: P9011, P9012, P9017, P9019, P9020, P9023, P9031, P9032, P9033, P9034, P9035, P9036, P9037, P9043, P9044, P9048, P9050, P9053, P9055, P9059, and P9060. Claims for dates of service on or after July 1, 2005, will be mass adjusted by the FIs to recover these overpayments.

5. Error in CR3681 Regarding Use of Bill Type 12X to Bill Blood and Blood Products

CR3681 incorrectly listed bill type 12X as a bill to be used for blood and blood products under the OPPS.

However, blood and blood products cannot be billed on the 12X because blood and blood products, like drugs, are covered as incident to a physician's service when furnished in a hospital outpatient department and cannot be paid when the service is furnished to a hospital inpatient, notwithstanding that the beneficiary has exhausted Part A benefits (the circumstance where bill type 12X is used).

6. Modification to the Long Descriptor for C8952

To clarify the current policy for drug administration, effective July 1, 2006, CMS is modifying the long descriptor for C8952 as shown in the following table:

Old HCPCS Long Descriptor for HCPCS code C8952	New HCPCS Long Descriptor for HCPCS code C8952
Therapeutic, prophylactic or diagnostic injection; intravenous push	Therapeutic, prophylactic or diagnostic injection; intravenous push of each new substance/drug

7. Revised Descriptors for C1767

As a reminder, the revised long descriptor for C1767 is "Generator, neurostimulator (implantable), non-rechargeable" and the revised short descriptor is "Generator, neuro non-recharge."

8. Payment for 20979, Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)

Effective for services furnished on or after July 1, 2006, CPT code 20979 is assigned to APC 0340, Minor Ancillary Procedures, with status indicator "X" under OPPS.

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9. Payment for Certain Pathology Services

Effective for services furnished on or after the dates listed in the table below, CPT codes listed in the following table are assigned to APC 0342, Level I Pathology, with status indicator "X" under OPPS:

CPT Code	Long Descriptor	Effective Date
81099	Unlisted urinalysis procedure	08/01/00
84999	Unlisted chemistry procedure	08/01/00
85999	Unlisted hematology and coagulation procedure	08/01/00
86849	Unlisted immunology procedure	08/01/00
87999	Unlisted microbiology procedure	08/01/00
88199	Unlisted cytopathology procedure	10/01/00
88399	Unlisted surgical pathology procedure	10/01/00
89240	Unlisted miscellaneous pathology test	01/01/04

10. Coverage Determinations

The fact that a drug, device, procedure, or service is assigned an 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 (FIs) determine whether a drug, device, procedure, or service meets all program requirements for coverage. For example:

- That the drug, device, procedure, or service is reasonable and necessary to treat the beneficiary's condition; and
- Whether the drug, device, procedure, or service is excluded from payment.

CR5121 further instructs your intermediary to:

- Not allow payment for any drugs billed using C9399 for which FDA approval was granted before January 1, 2004.
- Check the FDA's Web site at http://www.fda.gov/ to obtain the information on the FDA approval dates.
- Adjust as appropriate claims brought to their attention:
  - Whose dates of service fall within the timely filing limit; and
  - That contain at least one of the following HCPCS codes.

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HCPCS Code	Long Descriptor	HCPCS Code	Long Descriptor
81099	Unlisted urinalysis procedure	87999	Unlisted microbiology procedure
84999	Unlisted chemistry procedure	88199	Unlisted cytopathology procedure
85999	Unlisted hematology and coagulation procedure	88399	Unlisted miscellaneous pathology test
86849	Unlisted immunology procedure	89240	Unlisted miscellaneous pathology test

- Mass adjust claims that meet all of the following conditions:
  - Were incorrectly paid for services furnished on or after July 1, 2005 through June 30, 2006;
  - Were processed before the installation of the July 2006 OPPS PRICER; and
  - Contain any of the following HCPCS codes:

CPT/HCPCS	Descriptor	CPT/HCPCS	Descriptor
P9011	Blood (split unit)	P9036	Platelets, Pheresis, Irradiated
P9012	Cryoprecipitate	P9037	Platelets, Pheresis, Leukocytes reduced, Irradiated
P9017	Fresh frozen plasma (single donor) frozen within 8 hrs	P9043	Infusion, Plasma Protein Fraction (Human), 5%
P9019	Platelet concentrate	P9044	Plasma, Cryoprecipitate, reduced
P9020	Platelet rich plasma	P9048	Infusion, Plasma Protein Fraction (Human) 5%
P9023	Plasma, pooled multiple donor, solvent/ detergent treated, frozen	P9050	Granulocytes, pheresis
P9031	Platelets, Leukocytes reduced	P9053	Platelets pheresis, Leukocytes reduced, CMV-negative, irradiated
P9032	Platelets, Irradiated	P9055	Platelets, Leukocytes reduced, CMV-negative, apheresis/pheresis
P9033	Platelets, Leukocytes reduced, irradiated	P9059	Fresh frozen plasma, between 8-24 hours of collection
P9034	Platelets, Pheresis	P9060	Fresh frozen plasma, donor retested
P9035	Platelets, Pheresis, Leukocytes reduced		

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Additional Information

For complete details, please see the official instruction issued to your FI/RHHI regarding this change. That instruction may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R970CP.pdf on the CMS website.

If you have any questions, please contact your FI/RHHI 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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