Medicare Learning Network
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CMS
Information for Medicare Fee-For-Service Health Care Professionals

Flu Season is upon us! Begin now to take advantage of each office visit as an opportunity to talk with your patients about the flu virus and their risks for complications associated with the flu, and encourage them to get their flu shot. And don't forget, health care professionals need to protect themselves also. Get Your Flu Shot. – Protect yourself, your patients, and your family and friends. Remember - Influenza vaccination is a covered Part B benefit. Note that influenza vaccine is NOT a Part D covered drug. For information about Medicare's coverage of adult immunizations and educational resources, go to http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/SE0667.pdf on the CMS website.

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Note: This article was updated on October 24, 2012, to reflect current Web addresses. All other information remains unchanged.

October 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) 5304, which describes changes to the OPPS to be implemented in the October 2006 OPPS update.

Background

Change Request (CR) 5304 describes changes to, and billing instructions for, various payment policies implemented in the October 2006 OPPS update. The October 2006 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 CR5304.

In addition, the October 2006 revisions to OPPS OCE data files, instructions and specifications are provided in Change Request (CR) 5244, "October 2006 Outpatient Prospective Payment System Code Editor (OPPS OCE) Specifications Version 7.3." CR5244 can be found at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1045CP.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

Key changes in CR5304 include the following:

1. Device Edit Changes and Questions

a. Addition of HCPCS Code C1820, Generator, Neurostimulator (Implantable), with Rechargeable Battery and Charging System as an Allowed Device for CPT Code 64590, Insertion or Replacement of Peripheral Neurostimulator Pulse Generator or Receiver, Direct or Inductive Coupling

The HCPCS code C1820 has been added as an allowed device for CPT code 64590, based on newly received information that the rechargeable neurostimulator can be implanted for the purpose of stimulating peripheral nerves. This change is effective for services furnished on and after January 1, 2006, the effective date of HCPCS Code C1820.

b. Clarification Regarding Reporting Devices for Pacemakers

Claims containing CPT codes 33206, 33207, 33208, 33213 and 33214 for insertion of pacemakers and leads require both:

- A device code for a pacemaker, and
- A device code for pacemaker leads, which includes:
  - C1779, Lead, pacemaker, transvenous VDD single pass, or
  - C1898, Lead, pacemaker, other than transvenous VDD single pass).

In other words, in order to pass the OCE device edit, a claim for these procedure codes must have at least two devices on the claim: 1) a pacemaker from the column A list of allowed pacemakers for the procedure code being billed and 2) either C1779 or C1898 from column B devices.

2. List of Device Category Codes for Present or Previous Pass-Through

Payment and Related Definitions

CMS has posted a document on the OPPS website (http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html/HospitalOutpatientPPS/04_passthrough_payment.asp#TopOfPage) that provides a complete list of the device category codes used presently or previously for pass-through payment, along with their

expiration dates, and definitions that were published for certain device category C-codes.

CMS posted this list to facilitate the ability to track all present and previous categories for pass-through payment. Once on the CMS website (*http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html/HospitalOutpatientPPS/04_passthrough_payment.asp#TopOfPage*) select "Pass Through Payment Device Category Codes [PDF…]" from the Downloads section.

Note: This list does not include all device codes reportable in the OPPS; there are additional HCPCS codes for devices that were not eligible for pass-through payment. The *Medicare Claims Processing Manual* (Publication 100-04, Chapter 4, §61; http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf) provides detailed information on requirements for reporting device codes and satisfying device to procedure edits in the OPPS.

3. New Services

The following new service is assigned for payment under the OPPS:

HCPCS Code	Effective Date	SI	APC	Short Descriptor	Long Descriptor	Payment Rate	Minimum Unadjusted Copayment
C9727	10/01/06	S	1510	Insert palate implants	Insertion of implants into the soft palate; minimum of three implants	$850.00	$170.00

4. Drugs and Biologicals

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

In the CY 2006 OPPS final rule published in the Federal Register November 10, 2005 (70 FR 68643; http://www.access.gpo.gov/su_docs/fedreg/a051110c.html), 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. In cases where adjustments to payment rates are necessary, CMS will incorporate changes to the payment rates in the October 2006 release of the OPPS PRICER. The updated payment rates effective October 1, 2006, will be included in the October 2006 update of the OPPS Addendum A and Addendum B, which will be

posted at the end of September at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html/HospitalOutpatientPPS/AU/list.asp#TopOfPage on the CMS website.

b. Newly-Approved Drug Eligible for Pass-Through Status

The following drug has been designated as eligible for pass-through status under the OPPS effective October 1, 2006. The payment rate for this item can be found in the October 2006 update of OPPS Addendum A and Addendum B, which will posted on the CMS website (http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html/HospitalOutpatientPPS/AU/list.asp#TopOfPage) at the end of September, 2006.

HCPCS Code	APC	SI	Long Description
C9231	9231	G	Injection, decitabine, per 1 mg

c. Updated Payment Rate for HCPCS C9227, Injection, Micafungin Sodium, per 1mg, Effective April 1, 2006 through June 30, 2006

The payment rate for HCPCS Code C9227 was incorrect in the April 2006 OPPS PRICER. The corrected payment rate listed below has been installed in the October 2006 OPPS PRICER, effective for services furnished on April 1, 2006, through implementation of the July 2006 update.

HCPCS Code	APC	Short Description	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
C9227	9227	Injection, micafungin sodium	$1.89	$0.38

d. Updated Payment Rate for HCPCS C9230, Injection, Abatacept, per 10mg, Effective July 1, 2006 through September 30, 2006

The payment rate for HCPCS Code C9230 was incorrect in the July 2006 OPPS PRICER. The corrected payment rate listed below has been installed in the October 2006 OPPS PRICER, effective for services furnished on July 1, 2006, through implementation of the October 2006 update.

HCPCS	APC	Short Description	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
C9230	9230	Injection, abatacept	$19.08	$3.82

e. Payment Rate for CPT 90736, Zoster (Shingles) Vaccine, Live, for Subcutaneous Injection, Becomes Effective on its Date of FDA Approval

Currently, CPT Code 90736 is not payable under OPPS and is assigned to status indicator 'E'. The product described by this code was approved by the Food and Drug Administration (FDA) on May 25, 2006. Therefore, in the October 2006 OCE update, the status indicator for CPT 90736 will be changed from 'E' to 'K' to become payable under OPPS effective May 25, 2006.

CPT 90736 will map to APC 0745. The payment rate for APC 0745 can be found in the October 2006 update of OPPS Addendum A and Addendum B, which will posted on the CMS website at the end of September.

f. Correct Reporting of Units for Drugs

Note: 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 4.

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

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

5. Transitional Outpatient Payments

Effective January 1, 2005, CMS transitioned from metropolitan statistical areas (MSAs) to core based statistical areas (CBSAs).

CR3214 (Transmittal 82, issued on May 14, 2004; *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R82OTN.pdf*), instructed FIs to refer to the Inpatient Provider Specific File to determine whether a hospital was rural for purposes of TOPs payments. It also instructed FIs to populate both the Geographic/Actual MSA field and Wage Index MSA field in the Outpatient Provider Specific File (OPSF) using data from the inpatient regulations that were effective on and after October 1, 2004. (An MLN Matters article on CR3214 is available at *http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM3214.pdf* on the CMS website.)

CR3214 instructed that:

- Changes to wage index classifications that apply to the Inpatient PPS, on or after October 1 of any year, do not apply to the OPPS until January 1 of the next year; and
- FIs should use the OPSF to determine whether a provider was eligible for the Transitional Outpatient Payments System (TOPs) payments, beginning January 1, 2005.

CMS received several inquiries related to the transition from MSAs to CBSA and would like to clarify that it was anticipated FIs would automatically transition from MSAs to CBSAs as of January 1, 2005.

Therefore, effective January 1, 2005, a hospital is considered rural for purposes of TOPs payments if either the Geographic/Actual CBSA field or the Wage Index CBSA field is rural.

A hospital that was rural under MSAs but is urban under CBSAs is no longer eligible for TOPs payments as of January 1, 2005.

Note: Interim TOPs Calculation: If mutually agreed upon by both the FI and the provider, the FI can pay less than the monthly interim TOP payment (85% of the full hold harmless amount) to that provider to avoid significant overpayments throughout the year that must be paid back to the FI at cost report settlement. The interim TOPs payments would be reconciled at cost report settlement, as usual.

6. Coverage Determinations

The fact that a drug, device, procedure, or service is assigned 1) a HCPCS code and 2) a payment rate under the OPPS does not imply coverage by the Medicare program. It only indicates how the drug, device, procedure, or service may be paid if covered by the Medicare program.

FIs determine whether a drug, device, procedure, or service meets all Medicare program requirements for coverage, and whether:

- The drug, device, procedure, or service is or is not reasonable and necessary to treat the beneficiary's condition, or

The drug, device, procedure, or service is included in or excluded from payment.

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/R1060CP.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.