

MLN Matters Number: MM3915

Related Change Request (CR) #: 3915

Related CR Release Date: June 30, 2005

Effective Date: July 1, 2005

Related CR Transmittal #: 599

Implementation Date: July 5, 2005

July 2005 Update of the Hospital Outpatient Prospective Payment System (OPPS)

Note: This article was updated on February 11, 2013, to reflect current Web addresses. All other information remains unchanged.

Provider Types Affected

Providers billing Medicare fiscal intermediaries (FIs) for services paid under the Outpatient Prospective Payment System (OPPS)

Provider Action Needed



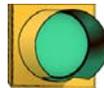
STOP – Impact to You

This article is based on information contained in Change Request (CR) 3915, which describes changes to the OPPS to be implemented in the July 2005 OPPS update.



CAUTION – What You Need to Know

Unless otherwise noted, all changes addressed in CR 3915 are effective for services furnished on or after July 1, 2005.



GO – What You Need to Do

Please see the *Background* and *Additional Information* sections of this instruction for further details regarding the July 2005 OPPS update.

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Background

This article is based on information contained in Change Request (CR) 3915, which describes changes to the OPSS to be implemented in the July 2005 OPSS update. The July 2005 OPSS Outpatient Code Editor (OCE) and OPSS PRICER will reflect additions, changes, and deletions to the following:

- The Healthcare Common Procedure Coding System (HCPCS);
- Ambulatory Payment Classification (APC);
- HCPCS Modifier; and
- Revenue Code.

Key OPSS changes for July 2005 (unless another date is specified) are described below.

Note: July 2005 revisions to the OPSS OCE data files, instructions, and specifications are provided in CR3871 (Transmittal 569, dated May 27, 2005, subject: "July 2005 Outpatient Prospective Payment System Code Editor (OPSS OCE) Specifications Version 6.2."). A MLN Matters article (MM3871) is available regarding those changes at <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM3871.pdf> on the CMS website.

1. Smoking and Tobacco-Use Cessation Counseling Services

CMS determined (effective March 22, 2005) that the evidence is adequate to conclude that smoking and tobacco-use cessation counseling is reasonable and necessary for:

- A patient who has a disease or an adverse health effect that has been found by the U.S. Surgeon General to be linked to tobacco use; or
- A patient taking a therapeutic agent whose metabolism or dosing is affected by tobacco use as based on FDA-approved information.

These individuals will be covered under Medicare Part B when certain conditions of coverage are met, subject to certain frequency and other limitations.

Note: Conditions of Medicare Part A and Medicare Part B coverage for smoking and tobacco-use cessation counseling services are summarized in a MLN Matters article (MM3834), which is available at <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM3834.pdf> on the CMS website.

For services furnished on or after March 22, 2005, hospitals should report the following HCPCS codes when billing for smoking and tobacco-use cessation counseling service:

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HCPCS	SI	Descriptor	APC
G0375	S	Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes Short Descriptor: Smoke/Tobacco counseling 3-10	1501
G0376	S	Smoking and tobacco-use cessation counseling visit; intensive, greater than 10 minutes Short Descriptor: Smoke/Tobacco counseling greater than 10	1501

Note: The above G codes will **NOT** be active in Medicare systems until July 5, 2005.

2. Drugs and Biologicals

a. Drugs with Payments Based on Average Sales Price (ASP) Effective July 1, 2005

CR3915 contains an extensive table of the drugs and biologicals whose payments under the OPSS will be established in accordance with the Average Sales Price (ASP) methodology that is used to calculate payment for drugs and biologicals in the physician office setting. To view the table, access CR3915 by visiting <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R599CP.pdf> on the CMS site.

The 2005 OPSS Final Rule (Federal Register, Volume 69, Number 219, page 65777 at: <http://edocket.access.gpo.gov/2004/04-24759.htm>), stated that payments for drugs and biologicals based on ASP 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 an appropriate quarterly release of the OPSS PRICER and will not be publishing the updated payment rates in the program instructions implementing the associated quarterly update of the OPSS. However, the updated payment rates can be found in the July update of OPSS Addendum A and Addendum B at <http://www.cms.gov/HospitalOutpatientPPS/Downloads/05JulyAddA.zip> and <http://www.cms.gov/HospitalOutpatientPPS/Downloads/05JulyAddB.zip> on the CMS website.

Single-indication orphan drugs payable under OPSS are also listed below. The methodology used to establish payment rates for these drugs is discussed in the 2005 OPSS Final Rule which can be found in Volume 69 of the Federal Register, Number 219, page 65807 (69 FR 65807) at <http://edocket.access.gpo.gov/2004/04-24759.htm>

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b. Updated Payment Rates for Certain Drugs, Biologicals and Services Effective April 1, 2005 through June 30, 2005

The payment rate for HCPCS J0135 (APC of 1083, Injection, Adalimumab, 20mg) was incorrect in the April 2005 OPSS PRICER. The corrected payment rate of \$294.63 will be installed in the July 2005 OPSS PRICER, effective for services furnished on April 1, 2005 through June 30, 2005. Your FI will automatically adjust any claims that were processed to payment between April 1, 2005 and July 1, 2005 that contained J0135 using the corrected payment rate.

c. Newly-Approved Drugs and Biologicals Eligible for Pass-Through Status

The following drugs and biologicals have been designated as eligible for pass-through status under the OPSS effective July 1, 2005. Payment rates for these items can be found in the July update of OPSS Addendum A and Addendum B at <http://www.cms.gov/HospitalOutpatientPPS/Downloads/05JulyAddA.zip> and <http://www.cms.gov/HospitalOutpatientPPS/Downloads/05JulyAddB.zip> on the CMS website.

HCPCS	APC	SI	Long Description
C9127	9127	G	Injection, Paclitaxel Protein Bound Particles, per 1 mg
C9128	9128	G	Injection, Pegaptamib Sodium, per 0.3 mg
C9129	9129	G	Injection, Clofarabine, per 1 mg
J8501*	0868	G	Aprepitant, oral, 5 mg

*J8501 was approved for pass-through status effective April 6, 2005.

3. Medical Nutrition Therapy Services

If a medical nutrition therapy service is provided in the hospital outpatient department, hospitals should bill their local Fiscal Intermediary (FI) using the UB-92 for an evaluation and management code. Hospitals should be reporting CPT codes 97802, 97803, and 97804 for medical nutrition therapy services to Medicare FIs using the UB-92 or its electronic equivalent.

4. Reprocessing of OPSS Claims Containing Certain Surgical Procedures

CMS discovered an error in the 2005 OPSS Pricer that miscalculates certain outlier payments. The error has been corrected in the July 2005 version of the OPSS Pricer. To correct prior payments, CMS is encouraging providers to notify their FI if they believe they should have received an outlier on claims that meet the following criteria:

- Claim has date of service January 1, 2003 or later; and
- Claim has date of service before July 1, 2005; and

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- Claim has one or more surgical procedure lines (lines with a status indicator of "T" (any HCPCS) or "S" with HCPCS codes greater than 09999 and less than 70000) that contain no surgical procedure lines with charges less than \$1.01.

5. No-Cost Device Coding

Effective for services furnished on or after April 1, 2005, all hospitals paid under the OPSS must report a code for a device when reporting the code for inserting the device. (See MLN Matters article MM3606 at <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM3606.pdf> on the CMS website.)

If an OPSS hospital fails to report a device code, edits installed in the outpatient code editor (OCE) for services furnished on or after April 1, 2005 will not allow the claim to be processed to payment. For example, if a hospital doesn't report the code for a pacemaker with the CPT code for the procedure performed to insert the pacemaker, OCE edits will cause the claim to be returned to the provider.

However, there are occasions when a hospital may furnish a device for surgical insertion for which it incurs no cost. These cases include, but are not limited to, devices replaced under warranty, due to recall, or due to defect in a previous device; devices provided in a clinical trial; or devices provided as a sample. The hospital charge for a device furnished to the hospital at no cost should equal \$0.00.

Some hospitals paid under the hospital outpatient prospective payment system (OPSS) might ordinarily report neither a code nor a charge for a device for which it incurred no cost, which would result in the claim failing the device edits installed in the OCE. Other hospitals have billing systems which require that a charge be reported for separately payable codes in order for the claim to be submitted for payment, even items for which the hospital incurs no cost.

Hospitals paid under the OPSS have asked that CMS clarify how devices furnished to beneficiaries for which the hospital incurs no cost should be reported. CMS advises hospitals as follows **for services furnished on or after April 1, 2005:**

- Hospitals paid under the OPSS that surgically implant a device furnished at no cost to the hospital must report the appropriate HCPCS code for the device on type of bill 13x.
- Hospitals paid under the OPSS that surgically implant a device furnished at no cost to the hospital must report a charge of zero for the device, or, if the hospital's billing system requires that a charge be entered, the hospital must submit a token charge (e.g. \$1.00) on the line with the device code.

Showing a token charge in this circumstance will allow claims for reasonable and necessary services to be paid.

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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/R599CP.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.

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