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MLN Matters® Number: MM5912

Related Change Request (CR) #: 5912

Related CR Release Date: January 18, 2008

Effective Date: January 1, 2008 (unless otherwise noted)

Related CR Transmittal #: R1417CP

Implementation Date: January 7, 2008

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

Note: This article was revised on April 28, 2016, to add a link to a related article ([SE1604](#)) that summarizes the available substance abuse treatment services and provides reference links to other online Medicare information with further details about these services. All other information remains the same

Provider Types Affected

Providers submitting claims to Medicare contractors (fiscal intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for outpatient services provided to Medicare beneficiaries and paid under the OPPS.

Impact on Providers

This article is based on Change Request (CR) 5912, which describes changes to the OPPS to be implemented in the January 2008 OPPS update. Be sure billing staffs are aware of these changes.

Background

CR 5912 describes changes to and billing instructions for various payment policies implemented in the January 2008 OPPS update. The January 2008 Integrated Outpatient Code Editor (I/OCE) changes are discussed in CR5865. MLN Matters article, MM5865, is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM5865.pdf> on the Centers for Medicare & Medicaid (CMS) website.

- The January 2008 I/OCE and OPPS PRICER will reflect January 2008 changes to:
- The Healthcare Common Procedure Coding System (HCPCS)
- Ambulatory Payment Classification (APC)
- HCPCS Modifier
- Revenue Code additions, changes, and deletions identified in this notification

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CR5912 affects Chapter 4, Sections 10, 20, 30, 50, 61, 70, 130, 160, 190, 200, 230, and 290; Chapter 16, Section 40.3; and Chapter 17, Section 90.2 of the “Medicare Claims Processing Manual”. CMS is reorganizing or deleting information in these sections. These manual revisions will be released in a future CR.

Key Changes

The key changes according to CR5912 are as follows:

- For CY2008, Medicare has created two parallel Level II HCPCS G-Codes (G0396 and G0397) to allow for proper reporting and payment of alcohol and substance abuse structured assessment and intervention services that are not provided as screening services, but that are performed in the context of the diagnosis or treatment of illness or injury. Medicare contractors will make payment under the OPPS for HCPCS code G0396 (Alcohol and/or substance (other than tobacco) abuse structured assessment (eg, AUDIT, DAST) and brief intervention, 15 to 30 minutes) and HCPCS code G0397, (Alcohol and/or substance (other than tobacco) abuse structured assessment (eg, AUDIT, DAST) and intervention greater than 30 minutes), only when appropriate, reasonable and necessary (i.e., when the service is provided to evaluate patients with signs/symptoms of illness or injury) as per section 1862(a)(1)(A) of the Social Security Act. For more information regarding this change, refer to CR5912.
- The Medicare, Medicaid, and SCHIP Extension Act of 2007 requires Medicare to pay for brachytherapy sources for the period of January 1 through June 30, 2008, at hospitals’ charges, adjusted to the costs (with the exception of C2637, which is non-payable). Therefore, the prospective payment rates for each source, which are listed in Addendum B of the VY2008 final rule for OPPS, will NOT be used for payment during that time period. Instead, the status indicators of brachytherapy source HCPCS codes (except C2637), which were previously paid at charges adjusted to cost, will remain “H” effective January 1 through June 30, 2008. Further instructions will be issued later for payment after June 30, 2008. CR5912 also has a table (Table 5) containing a comprehensive list of brachytherapy sources payable as of January 1, 2008.
- Table 9 of CR5912 contains updated payment rates for certain HCPCS codes (J0152, J0881, J1438, J1440, J1441, J2425, J2505, J0215, J0289, J1740, J7342, J8560, and J9268) that are effective January 1, 2007 through March 31, 2007. The Medicare contractors will adjust as appropriate claims you bring to their attention that:
 - Have dates of service that fall on or after January 1, 2007, but prior to April 1, 2007
 - Contain HCPCS code listed in Table 9 which is included in the business requirements section of CR5912
 - Were originally processed prior to the installation of the January 2008 OPPS Pricer

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- Table 10 of CR5912 contains updated payment rates for selected drugs and biologicals (HCPCS codes J0881, J1324, J1438, J1440, J1441, J2425, and J2502) that are effective from April 1, 2007 through June 30, 2007. Medicare contractors will adjust as appropriate claims you bring to their attention that:
 - Have dates of service that fall on or after April 1, 2007, but prior to July 1, 2007
 - Contain HCPCS code listed in Table 11
 - Were originally processed prior to the installation of the January 2008 OPSS Pricer
- Table 11 of CR5912 contains updated payment rates for selected drugs and biologicals (HCPCS codes J0881, J1438, J1440, J1441, J2505, Q3025, and Q4089) that are effective from July 1, 2007 through September 30, 2007. Medicare contractors will adjust as appropriate claims you bring to their attention that:
 - Have dates of service that fall on or after July 1, 2007, but prior to October 1, 2007
 - Contain HCPCS code listed in Table 11
 - Were originally processed prior to the installation of the January 2008 OPSS Pricer
- The Medicare, Medicaid, and SCHIP Extension Act of 2007 requires CMS to pay for therapeutic radiopharmaceuticals for the period of January 1 through June 30, 2008 at hospitals' charges adjusted to the costs. Therefore, the prospective payment rates for each therapeutic radiopharmaceutical, which are listed in Addendum B of the CY2008 final rule from CMS dated November 27, 2007, will NOT be used for payment of therapeutic radiopharmaceuticals from January 1 through June 30, 2008. Instead, the status indicators of therapeutic radiopharmaceutical HCPCS codes which were previously paid at charges adjusted to costs will remain at "H" effective January 1 through June 30, 2008, for payment at hospitals' charges adjusted to costs. The codes for therapeutic radiopharmaceuticals, long descriptors, status indicators, and APCs for CY2008 are listed in Table 12 of CR5912.
- Effective January 1, 2008, Medicare contractors will return to the provider claims that report a nuclear medicine service but do not also report a diagnostic radiopharmaceutical.
- Providers who bill A/B MACs and RHHIs need to be aware that C-codes: C9237, C9240, C9354, and C9355 are included in the January 2008 I/OCE update. However, these codes are not on the 2008 HCPCS file. Contractors will manually add these codes to their systems. Status and payment indicators for these codes will be listed in the January 2008 update of the OPSS Addendum A and Addendum B at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html> on the CMS website.

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CR5912 is quite lengthy and also includes important changes regarding certain OPPS issues. These details will not be repeated in this article, but are available in CR5912 at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1417CP.pdf> on the CMS website for those details. The issues discussed in CR5912 include:

- Payment for cardiac rehabilitation services and the medical evaluation which is required to meet the Medicare comprehensive program requirements
- Payment for extended assessment and management composite APCs, including a table (Table 1 of CR5912) that shows criteria for composite payment
- Payment for direct admission to observation, including a discussion of HCPCS codes used for these services;
- Changes to packaged services for the 2008 OPPS, including a table (Table 2 of CR5912) of composite APCs and criteria for composite payment
- Billing for wound care services, including a list of revisions to revenue codes that may be reported with CPT codes 97597, 97598, 97602, 97605, and 97606;
- Billing for bone marrow and stem cell processing services
- Update billing for implantable cardioverter defibrillators (ICDs), which reports that the four Level II HCPCS codes (G0297, G0298, G0299, and G0300) are deleted effective January 1, 2008, and hospitals are required to bill the appropriate CPT codes, specifically 33240 or 33249, as appropriate, along with the applicable device C-codes, for payment under the OPPS
- Adjustment to payment in cases of devices replaced with partial credit for the replaced device, including two helpful tables (Tables 4.1 and 4.2) regarding the use of the FC modifier
- Changes to device edits for 2008, including a reference that these edits are available under the “downloads” section at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html> on the CMS website
- As previously mentioned, a discussion of payment for brachytherapy sources, including a table (Table 5) that lists brachytherapy sources payable as of January 1, 2008, along with associated APCs and payment rates
- Billing for drugs and biologicals, including a table (Table 6) of new 2008 HCPCS codes (A9501, A0509, A9569, A9570, A9571, A9576, A9577, A9578, C9237, C9238, C9239, C9240, C9354, C9355, J0400, J1573, J2724, and J9226), a table (Table 7) of HCPCS code and dosage descriptor changes for 2008, a table (Table 8) of new drugs separately payable under OPPS in 2008 (C9237 - (Injection, lanreotide acetate, 1mg) and C9240 – (Injection, ixabepilone, 1mg)
- New Drug Administration codes for 2008 (90769, 90770, 90771, and 90776)

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- Billing for cardiac echocardiography services, including a table (Table 13) of HCPCS codes for echocardiograms with contrast (HCPCS codes C8921, C8922, C8923, C8924, C8925, C8926, C8927, and C8928)
- Modification of the methodology for calculating hospital overall cost-to-charge ratios for hospitals that have nursing and paramedical education programs
- Changes to the OPPS PRICER logic
- OCE logic changes for the partial hospitalization program (PHP) services

Additional Information

To see the official instruction (CR5912) issued to your Medicare FI, RHHI or A/B MAC refer to <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1417CP.pdf> on the CMS website.

If you have questions, please contact your Medicare FI, RHHI 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>.

Document History

Date of Change	Description
April 28, 2016	The article was revised to add a link to a related article (<i>SE1604</i>) that summarizes the available substance abuse treatment services and provides reference links to other online Medicare information with further details about these services. All other information remains the same.
August 14, 2012,	The article was updated to reflect current Web addresses.

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