CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 786

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: DECEMBER 16, 2005

Change Request 4250

SUBJECT: January 2006 Update of the Hospital Outpatient Prospective Payment System (OPPS): Summary of Payment Policy Changes, OPPS PRICER Logic Changes, and Instructions for Updating the Outpatient Provider Specific File (OPSF)

I. SUMMARY OF CHANGES: This Recurring Update Notification describes changes to, and billing instructions for, various payment policies implemented in the January 2006 OPPS update. This notification further describes changes to the OPPS PRICER logic and provides instructions for updating the Outpatient Provider Specific File (OPSF).

NEW/REVISED MATERIAL

EFFECTIVE DATE: January 1, 2006

IMPLEMENTATION DATE: January 3, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R = REVISED, N = NEW, D = DELETED – *Only One Per Row.*

R/N/D	Chapter / Section / SubSection / Title

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Recurring Update Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 786	Date: December 16, 2005	Change Request 4250

SUBJECT: January 2006 Update of the Hospital Outpatient Prospective Payment System (OPPS): Summary of Payment Policy Changes, OPPS PRICER Logic Changes and Instructions for Updating the Outpatient Provider Specific File (OPSF)

I. GENERAL INFORMATION

A. Background: This Recurring Update Notification describes changes to, and billing instructions for, various payment policies implemented in the January 2006 OPPS update. The January 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 this notification. This notification further describes changes to the OPPS PRICER logic and provides instructions for updating the Outpatient Provider Specific File (OPSF).

January 2006 revisions to OPPS OCE data files, instructions and specifications are provided in Change Request (CR) 4238, "January 2006 Outpatient Prospective Payment System Code Editor (OPPS OCE) Specifications Version 7.0"

Instructions for drug administration, observation, and IVIG will be issued separately.

B. Policy:

1. Changes to the OPPS PRICER Logic

a. Hospitals reclassified for IPPS effective October 1, 2005, will be reclassified for OPPS effective January 1, 2006.

b. Section 401 designations and floor MSA designations effective October 1, 2005, will be effective for OPPS January 1, 2006.

c. Rural sole community hospitals will receive a 7.1 percent payment increase in 2006.

d. New OPPS payment rates and coinsurance amounts will be effective January 1, 2006. All coinsurance rates will be limited to 40 percent of the APC payment rate. Coinsurance rates cannot exceed the inpatient deductible of $952.

e. For hospitals outlier payments under OPPS, there will be no change in the multiple threshold of 1.75. This threshold of 1.75 is multiplied by the total line item APC payment to determine eligibility for outlier payments. This factor also is used to determine the outlier payment, which is 50 percent of estimated cost less 1.75 times the APC payment amount. The payment formula is (cost – (APC payment x 1.75))/2.

However, there will be a change in the fixed threshold. The estimated cost of service must be greater than the APC payment amount plus $1,250 in order to qualify for outlier payments. The previous fixed dollar threshold was $1,175.

f. For outliers for Community Mental Health Centers (CMHCs; bill type 76x), there will be a new multiple threshold of 3.4. The previous threshold was 3.5. The new threshold of 3.4 is multiplied by the total line item APC payment to determine eligibility for outlier payments. This factor is also used to determine the outlier payment, which is 50 percent of estimated costs less 3.4 times the APC payment amount. The payment formula is (cost – (APC payment x 3.4))/2.

2. Entering Outpatient Provider Records for Home Health Agencies and Hospices to Allow for Certain OPPS Payments (Effective January 1, 2005)

Change Request 3632 (Transmittal 423), issued on January 6, 2005, provided the January 2005 update to the hospital Outpatient Prospective Payment System (OPPS). Among other things, CR 3632 instructed contractors to enter the actual location Core-Based Statistical Area (CBSA) for all non-IPPS providers in the Actual Location CBSA field (file position 80-84) of the Outpatient Provider Specific File (OPSF). Contractors were also instructed to enter a "special wage index" in the OPSF for providers who either qualified to receive: **1)** a blended wage index, **2)** a "Hold Harmless" Provision, and/or **3)** a "Section 505 Out-Commuting" adjustment. The value for the "special wage index" was provided on CR 3632's attachments.

Later in 2005, CMS was notified that Home Health Agencies (HHAs) and Hospices were omitted from CMS is aware that some Regional Home Health Intermediaries (RHHIs) and Fiscal Intermediaries (FIs) have already updated the OPSF appropriately to allow their HHAs and Hospices to be paid under the OPPS for the specific service items. For RHHIs and FIs who have not already done so, CMS instructs that you create a record in the OPSF (effective January 1, 2005) for HHAs or Hospices whose OPPS services have been rejected due to not having a CBSA (or special wage index when applicable).

Please note that CMS is providing a list of the appropriate CBSA and/or special wage index value for HHA and Hospice providers on the following Pricer PPS Web site (under the OPSF section): (http://www.cms.hhs.gov/providers/pricer/default.asp?). Contractors who need to update the CBSA or special wage index in the OPSF for HHA or Hospices, can utilize this list to do so.

3. Updating the Outpatient Specific File (Effective January 1, 2006)

For January 1, 2006, contractors shall maintain the accuracy of the provider records in the Outpatient Providers Specific File (OPSF). This includes updating the CBSA in the provider records, as well as updating the "special wage index" value for those providers who qualify for the 505 adjustment and/or are held harmless (for re-designation from an urban MSA to a rural CBSA under the new geographic definitions) as annotated in Table 1[1].

[1] Table 1 includes a list of CBSAs and special wage index values for Non-IPPS hospitals (based on November OCSCAR data and the October OPSF) that are eligible to receive either the 505 adjustment in CY 2006 and/or qualify for the hold harmless provision in CY 2006. A final special wage index is given

When HHA or hospice claims subject to OPPS are suspended for lack of provider wage index information, contractors shall do the following to update the OPSF (effective 1/1/2006):

1) Update the CBSA value for each provider (as given in Table 1).

2) For providers who qualify for the 505 adjustment and/or are held harmless in CY 2006:

   a) Enter a value of "1" in the Special Payment Indicator field on the OPSF,; and

   b) Enter the final wage index value (given for the provider in Table 1) in the Special Wage Index field in the OPSF.

3) For providers who received a special wage index in CY 2005, but no longer receive it in CY 2006:

   a) Create a new provider record, effective January 1, 2006; and

   b) Enter a blank or "Y" in the special payment indicator field; and

   c) Enter zeroes in the special wage index field.

NOTE: Although the 505 adjustment is static for each qualifying county for 3 years, the special wage index will need to be updated (using the final wage index in Table 1) because the post-reclassification CBSA wage index has changed.

Table 1: Wage Index by CBSA for NON-IPPS Hospitals that are Eligible for the CBSA Hold Harmless Provision and Section 505 Out-Commuting Adjustment

Provider	CBSA	Section 505 Out Commuting Adjustment	Hold Harmless	Final Wage Index
013027	33660	YES	YES	0.8019
014008	33660	YES	YES	0.8019
014009	19460	YES		0.8601
042007	38220	YES		0.8733
052035	42044	YES		1.1576
052037	40140	YES		1.1194
052039	42044	YES		1.1576
052040	40140	YES		1.1194
053034	42044	YES		1.1576
053037	40140	YES		1.1194
053304	42044	YES		1.1576

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for each hospital and the components of that final wage index. All other providers not subject to a special wage index, should use the post reclassification wage index for their CBSA location.

Provider	CBSA	Section 505 Out Commuting Adjustment	Hold Harmless	Final Wage Index
053306	42044	YES		1.1576
053308	42044	YES		1.1576
054020	41884	YES		1.5000
054074	46700	YES		1.5194
054077	37100	YES		1.1769
054089	41884	YES		1.5000
054093	40140	YES		1.1194
054106	37100	YES		1.1769
054111	40140	YES		1.1194
054122	34900	YES		1.3108
054123	44700	YES		1.1884
054135	42044	YES		1.1576
054141	46700	YES		1.5194
054144	41884	YES		1.5000
064007	14500	YES		0.9936
073026	07	YES		1.1735
074000	14860	YES		1.2648
074003	25540	YES		1.1799
074008	07	YES		1.1735
074012	14860	YES		1.2648
074014	14860	YES		1.2648
082000	48864	YES		1.0579
083300	48864	YES		1.0579
084001	48864	YES		1.0579
084002	48864	YES		1.0579
084003	48864	YES		1.0579
114018	11	YES		0.7940
154047	15	YES		0.8815
154050	23060	YES	YES	1.0203
183028	21060	YES		0.8890
184012	21060	YES		0.8890
192034	29180	YES	YES	0.8655
192036	19	YES		0.7839
192040	19	YES		0.7839
192046	19	YES		0.8083
192050	29180		YES	0.8420
193044	19	YES		0.7839
193055	19	YES		0.7599
193063	19	YES		0.7839
193067	29180		YES	0.8420
193068	19	YES		0.7839

Provider	CBSA	Section 505 Out Commuting Adjustment	Hold Harmless	Final Wage Index
193073	29180	YES	YES	0.8655
193081	29180		YES	0.8420
193088	29180		YES	0.8420
193091	19	YES		0.7545
194047	43340	YES	YES	0.9463
194063	35380		YES	0.8993
212002	25180	YES		0.9647
213029	13644	YES		1.1499
214001	12580	YES		1.0091
214003	25180	YES		0.9647
214013	13644	YES		1.1499
222000	15764	YES		1.1415
222003	15764	YES		1.1415
222026	21604	YES		1.1021
222044	21604	YES		1.1021
222047	21604	YES		1.1021
222048	49340	YES		1.1090
223026	15764	YES		1.1415
223028	21604	YES		1.1021
223029	49340	YES		1.1090
223033	49340	YES		1.1090
224007	15764	YES		1.1415
224022	15764	YES		1.1415
224026	49340	YES		1.1090
224032	49340	YES		1.1090
224033	21604	YES		1.1021
224038	15764	YES		1.1415
232020	13020	YES		0.9624
232023	47644	YES		0.9950
232025	35660	YES		0.9102
232028	12980	YES		0.9635
232034	24340	YES	YES	1.0074
232036	27100	YES		0.9680
233025	12980	YES		0.9635
233028	47644	YES		0.9959
233031	47644	YES		0.9950
234011	47644	YES		0.9959
234021	47644	YES		0.9950
234023	47644	YES		0.9959
234024	47644	YES		0.9950
234037	12980	YES		0.9635

Provider	CBSA	Section 505 Out Commuting Adjustment	Hold Harmless	Final Wage Index
254009	37700	YES		0.8450
293029	16180	YES		1.0245
303026	40484	YES		1.1922
304001	40484	YES		1.1922
312018	20764	YES		1.1640
313025	35084	YES		1.2230
313027	45940	YES		1.1319
314010	35084	YES		1.2230
314011	20764	YES		1.1640
314013	45940	YES		1.1319
314020	35084	YES		1.2230
314025	45940	YES		1.1319
322001	32	YES		0.9269
323025	32	YES		0.9269
323032	29740	YES		0.8703
324007	29740	YES		0.8703
324009	29740	YES		0.8703
324010	29740	YES		0.8703
324011	32	YES		0.9082
324012	29740	YES		0.8703
330354	27460		YES	0.8217
334017	39100	YES		1.1452
334061	39100	YES		1.1452
344001	39580	YES		0.9721
344004	34	YES		0.9505
344011	39580	YES		0.9721
344014	39580	YES		0.9721
362007	36	YES		0.9039
362032	15940	YES		0.8976
364031	15940	YES		0.8976
364040	44220	YES		0.8994
372016	21420		YES	0.8673
374017	37	YES		0.7800
384008	41420	YES		1.0510
392031	27780	YES		0.8352
392034	10900	YES		1.1427
393026	39740	YES		0.9888
393036	27780		YES	0.8340
393037	49620	YES		0.9447
394014	39740	YES		0.9888
394016	39	YES		0.8342

Provider	CBSA	Section 505 Out Commuting Adjustment	Hold Harmless	Final Wage Index
394019	27780		YES	0.8340
394020	30140	YES		0.8904
423029	11340	YES		0.9198
424011	11340	YES		0.9198
444006	27740	YES		0.8014
444008	44	YES		0.8410
452018	23104	YES		0.9588
452019	23104	YES		0.9588
452028	23104	YES		0.9588
452088	23104	YES		0.9588
453040	23104	YES		0.9588
453041	23104	YES		0.9588
453042	23104	YES		0.9588
453089	45	YES		0.8248
453300	23104	YES		0.9588
453303	23104	YES		0.9588
454009	45	YES		0.8381
454012	23104	YES		0.9588
454019	23104	YES		0.9588
454051	23104	YES		0.9588
454052	23104	YES		0.9588
454061	23104	YES		0.9588
454086	23104	YES		0.9588
494029	49	YES		0.8047
503301	45104	YES		1.0793
504003	45104	YES		1.0793
504010	45104	YES		1.0793
513025	48540	YES		0.8938
522005	39540	YES		0.9707
523026	39540	YES		0.9707
524020	52	YES		0.9625
524021	52	YES		0.9805

4. New Services

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

Table 2: New Coding Information for Placement and Removal (If Performed)

of Applicator into Breast for Radiation Therapy

HCPCS	Effective Date	SI	APC	Short Descriptor	Long Descriptor	Payment	Minimum Unadjusted Copayment
C9726	01/01/06	S	1508	Rxt breast appl place/remov	Placement and removal (if performed) of applicator into breast for radiation therapy	$650.00	$130.00

5. New Device Pass-Through Category

Section 1833(t)(6)(B) of the Social Security Act requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least 2, but not more than 3 years. Section 1833(t)(6)(B)(ii)(IV) of the Act requires that we create additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices.

We are establishing one new device pass-through category as of January 1, 2006. The following table provides a listing of new coding and payment information concerning the new device category for transitional pass-through payment.

Table 3: New Device Category Pass-Through Coding Information

HCPCS	Effective Date	SI	APC	Short Descriptor	Long Descriptor	Device Offset from Payment
C1820	01/01/06	H	1820	Generator neuro rechg bat sys	Generator, neurostimulator (implantable), with rechargeable battery and charging system	$8,647.81 (applied to APC 222)

We are providing this information in advance of the actual effective date for the provisions in the November 10, 2005 final rule with comment period to ensure that our claims processing modules are prepared to accept claims that report HCPCS code C1820 for services furnished on or after January 1, 2006. However, should the Congress not approve the November 10, 2005 final rule with comment period for implementation in January 2006, we would issue appropriate instructions to inform contractors and hospitals of any changes resulting from that action. The instructions and codes in this Change Request

related to new HCPCS code C1820, new APC 1820, and revisions to the descriptors for HCPCS code C1767 are not effective for services furnished before January 1, 2006.

Device Offset from Payment

Section 1833(t)(6)(D)(ii) of the Act requires that we deduct from pass-through payments for devices an amount that reflects the portion of the APC payment amount that we determine is associated with the cost of the device (70 FR 68627-8). We have determined that we are able to identify the portion of the APC payment amount associated with the cost of the historically utilized device, that is, the non-rechargeable neurostimulator generator implanted through procedures assigned to APC 222, Implantation of Neurological Device, that C1820 would replace. The device offset from the pass-through payment for C1820 represents the deduction from the pass-through payment for category C1820 that will be made when C1820 is billed with a service assigned to APC 222. Please note that the offset amount from the APC payment is wage adjusted before it is subtracted from the device cost.

6. Revision of Device Category Descriptor for C1767

Section 1833(t)(6)(B)(ii)(IV) of the Act and 42 CFR 419.66(c)(1) require that we establish a new category for a medical device when no existing or previously existing device category is appropriate for the device (67 FR 66781). In the November 10, 2005 OPPS final rule with comment period for CY 2006, we announced that effective January 1, 2006, we will create an additional category for devices that meet all of the criteria required to establish a new category for pass-through payment in instances where we believe that an existing or previously existing category descriptor does not appropriately describe the new type of device. We further announced that this may entail the need to clarify or refine the short or long descriptors of the previous category. We indicated that we will evaluate each situation on a case-by-case basis using 2 tests described in the November 10, 2005 final rule with comment period. Any such clarification to a category descriptor will be made prospectively from the date the new category would be made effective. (70 FR 68631)

With the creation of C1820, Generator, neurostimulator (implantable), with rechargeable battery and charging system, as described above, we have determined that it is necessary to modify the current short and long descriptors of C1767, Generator, neurostimulator (implantable).

Effective January 1, 2006, the revised descriptors for C1767 are:
Revised long descriptor: Generator, neurostimulator (implantable), non-rechargeable
Revised short descriptor: Generator, neuro non-recharge

These revisions to category C1767's descriptors are effective from January 1, 2006 onwards, and do not apply to claims for services provided prior to January 1, 2006.

NOTE: January 2006 OPPS OCE does not contain the revised short descriptor for C1767. However, the correct short descriptor is listed in the January 2006 update of OPPS Addendum B on the CMS Website. The revised short descriptor will be included in the April 2006 OCE update.

7. Modifier-FB; Item Provided Without Cost to Provider, Supplier or Practitioner (Examples, but not Limited to: Covered Under Warranty, Replaced Due to Defect, Free Samples)

Effective for services furnished on or after January 1, 2006, hospitals must report HCPCS modifier -FB with the HCPCS code for a device which was furnished to the hospital without cost to the provider. For example, when a manufacturer furnishes a replacement device which has been recalled or which has failed and which was furnished to the provider without cost to the provider, the hospital must report the modifier with the device code to indicate that the hospital did not incur a cost for the item. This requirement applies to all HCPCS alphanumeric device codes with initial letter of "C" or "L". Hospitals should submit a token charge (e.g., $1.00) on the line with the device code for the claim to be accepted and processed. If the hospital uses a device that was furnished to it for no cost, but for which the usual cost to the hospital is greater than $50.00, and for which there is no suitable HCPCS alphanumeric code beginning with initial letter of "C" or "L", the hospital must use the modifier with the procedure code for the service in which the device is used.

8. Modifier -52

Effective for services provided January 1, 2006, a 50 percent reduction will be made for those services to which a -52 modifier is appended. The -52 modifier is used to indicate that a service that did not require anesthesia was partially reduced or discontinued at the physician's discretion. The physician may discontinue or cancel a procedure that is not completed in its entirety due to a number of circumstances, such as adverse patient reaction or medical judgment that completion of the full study is unnecessary. The modifier is reported most often to identify interrupted or reduced radiological and imaging procedures, and prior to January 1, 2006, policy has been to make full payment for procedures with a -52 modifier.

Hospitals should continue to use modifier -52, as appropriate, to report interrupted procedures that do not require anesthesia.

9. Billing for Drugs, Biologicals, and Radiopharmaceuticals

a. New HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals

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 units of service of the reported HCPCS code are consistent with the quantity of a drug, biological, or radiopharmaceutical that was actually administered to the patient. For CY 2006, many HCPCS codes for drugs, biologicals, and radiopharmaceuticals have undergone changes in their HCPCS code descriptors. In addition, many temporary C-codes and Q-codes have also been deleted effective December 31, 2005 and replaced with permanent HCPCS codes in CY 2006. Hospitals should pay close attention to accurate billing for units of service consistent with the dosages contained in the new long descriptors of the active CY 2006 HCPCS codes. The affected HCPCS codes are listed below:

Table 4: New HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals

CY 2005 Code	CY 2005 HCPCS Description	CY 2006 Code	CY 2006 HCPCS Description
A4642	SUPPLY OF SATUMOMAB PENDETIDE, RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, PER DOSE	A4642	INDIUM IN-111 SATUMOMAB PENDETIDE, DIAGNOSTIC, PER STUDY DOSE, UP TO 6 MILLICURIES
A9500	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, TECHNETIUM TC 99M SESTAMIBI, PER DOSE	A9500	TECHNETIUM TC-99M SESTAMIBI, DIAGNOSTIC, PER STUDY DOSE, UP TO 40 MILLICURIES
A9502	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, TECHNETIUM TC 99M TETROFOSMIN, PER UNIT DOSE	A9502	TECHNETIUM TC-99M TETROFOSMIN, DIAGNOSTIC, PER STUDY DOSE, UP TO 40 MILLICURIES
A9503	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, TECHNETIUM TC 99M, MEDRONATE, UP TO 30 MCI	A9503	TECHNETIUM TC-99M MEDRONATE, DIAGNOSTIC, PER STUDY DOSE, UP TO 30 MILLICURIES
A9504	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, TECHNETIUM TC 99M APCITIDE	A9504	TECHNETIUM TC-99M APCITIDE, DIAGNOSTIC, PER STUDY DOSE, UP TO 20 MILLICURIES
A9505	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, THALLOUS CHLORIDE TL 201, PER MCI	A9505	THALLIUM TL-201 THALLOUS CHLORIDE, DIAGNOSTIC, PER MILLICURIE
A9507	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, INDIUM IN 111 CAPROMAB PENDETIDE, PER DOSE	A9507	INDIUM IN-111 CAPROMAB PENDETIDE, DIAGNOSTIC, PER STUDY DOSE, UP TO 10 MILLICURIES
A9508	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, IOBENGUANE SULFATE I-131, PER 0.5 MCI	A9508	IODINE I-131 IOBENGUANE SULFATE, DIAGNOSTIC, PER 0.5 MILLICURIE
A9510	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, TECHNETIUM TC99M DISOFENIN, PER VIAL	A9510	TECHNETIUM TC-99M DISOFENIN, DIAGNOSTIC, PER STUDY DOSE, UP TO 15 MILLICURIES
A9511	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, TECHNETIUM TC 99M, DEPREOTIDE, PER MCI	A9536	TECHNETIUM TC-99M DEPREOTIDE, DIAGNOSTIC, PER STUDY DOSE, UP TO 35 MILLICURIES

CY 2005 Code	CY 2005 HCPCS Description	CY 2006 Code	CY 2006 HCPCS Description
A9512	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, TECHNETIUM TC-99M PERTECHNETATE, PER MCI	A9512	TECHNETIUM TC-99M PERTECHNETATE, DIAGNOSTIC, PER MILLICURIE
A9513	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, TECHNETIUM TC-99M MEBROFENIN, PER MCI	A9537	TECHNETIUM TC-99M MEBROFENIN, DIAGNOSTIC, PER STUDY DOSE, UP TO 15 MILLICURIES
A9514	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, TECHNETIUM TC-99M PYROPHOSPHATE, PER MCI	A9538	TECHNETIUM TC-99M PYROPHOSPHATE, DIAGNOSTIC, PER STUDY DOSE, UP TO 25 MILLICURIES
A9515	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, TECHNETIUM TC-99M PENTETATE, PER MCI	A9539	TECHNETIUM TC-99M PENTETATE, DIAGNOSTIC, PER STUDY DOSE, UP TO 25 MILLICURIES
A9516	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, I-123 SODIUM IODIDE CAPSULE, PER 100 UCI	A9516	IODINE I-123 SODIUM IODIDE CAPSULE(S), DIAGNOSTIC, PER 100 MICROCURIES
A9517	SUPPLY OF RADIOPHARMACEUTICAL THERAPEUTIC IMAGING AGENT, I-131 SODIUM IODIDE CAPSULE, PER MCI	A9517	IODINE I-131 SODIUM IODIDE CAPSULE(S), THERAPEUTIC, PER MILLICURIE
A9519	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, TECHNETIUM TC-99M MACROAGGREGATED ALBUMIN, PER MCI	A9540	TECHNETIUM TC-99M MACROAGGREGATED ALBUMIN, DIAGNOSTIC, PER STUDY DOSE, UP TO 10 MILLICURIES
A9520	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, TECHNETIUM TC-99M SULFUR COLLOID, PER MCI	A9541	TECHNETIUM TC-99M SULFUR COLLOID, DIAGNOSTIC, PER STUDY DOSE, UP TO 20 MILLICURIES
A9521	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, TECHNETIUM TC-99M EXAMETAZINE, PER DOSE	A9521	TECHNETIUM TC-99M EXAMETAZIME, DIAGNOSTIC, PER STUDY ODSE, UP TO 25 MILLICURIES
A9524	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, IODINATED I-131 SERUM ALBUMIN, 5 MICROCURIES	A9524	IODINE I-131 IODINATED SERUM ALBUMIN, DIAGNOSTIC, PER 5 MICROCURIES

CY 2005 Code	CY 2005 HCPCS Description	CY 2006 Code	CY 2006 HCPCS Description
A9526	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, AMMONIA N-13, PER DOSE	A9526	NITROGEN N-13 AMMONIA, DIAGNOSTIC, PER STUDY DOSE, UP TO 40 MILLICURIES
A9528	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC AGENT, I-131 SODIUM IODIDE CAPSULE, PER MILLICURIE	A9528	IODINE I-131 SODIUM IODIDE CAPSULE(S), DIAGNOSTIC, PER MILLICURIE
A9529	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC AGENT, I-131 SODIUM IODIDE SOLUTION, PER MILLICURIE	A9529	IODINE I-131 SODIUM IODIDE SOLUTION, DIAGNOSTIC, PER MILLICURIE
A9530	SUPPLY OF RADIOPHARMACEUTICAL THERAPEUTIC AGENT, I-131 SODIUM IODIDE SOLUTION, PER MILLICURIE	A9530	IODINE I-131 SODIUM IODIDE SOLUTION, THERAPEUTIC, PER MILLICURIE
A9531	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC AGENT, I-131 SODIUM IODIDE, PER MICROCURIE (UP TO 100 MICROCURIES)	A9531	IODINE I-131 SODIUM IODIDE, DIAGNOSTIC, PER MICROCURIE (UP TO 100 MICROCURIES)
A9532	SUPPLY OF RADIOPHARMACEUTICAL THERAPEUTIC AGENT, IODINATED I-125, SERUM ALBUMIN, 5 MICROCURIES	A9532	IODINE I-125 SERUM ALBUMIN, DIAGNOSTIC, PER 5 MICROCURIES
A9600	SUPPLY OF THERAPEUTIC RADIOPHARMACEUTICAL, STRONTIUM-89 CHLORIDE, PER MCI	A9600	STRONTIUM SR-89 CHLORIDE, THERAPEUTIC, PER MILLICURIE
A9605	SUPPLY OF THERAPEUTIC RADIOPHARMACEUTICAL, SAMARIUM SM 153 LEXIDRONAMM, 50 MCI	A9605	SAMARIUM SM-153 LEXIDRONAMM, THERAPEUTIC, PER 50 MILLICURIES
C1079	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, CYANOCOBALAMIN CO 57/58, PER 0.5 MICROCURIE	A9546	COBALT CO-57/58, CYANOCOBALAMIN, DIAGNOSTIC, PER STUDY DOSE, UP TO 1 MICROCURIE
C1080	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, I-131 TOSITUMOMAB, PER DOSE	A9544	IODINE I-131 TOSITUMOMAB, DIAGNOSTIC, PER STUDY DOSE
C1081	SUPPLY OF RADIOPHARMACEUTICAL THERAPEUTIC IMAGING AGENT, I-131 TOSITUMOMAB, PER DOSE	A9545	IODINE I-131 TOSITUMOMAB, THERAPEUTIC, PER TREATMENT DOSE
C1082	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, INDIUM-111 IBRITUMOMAB TIUXETAN, PER DOSE	A9542	INDIUM IN-111 IBRITUMOMAB TIUXETAN, DIAGNOSTIC, PER STUDY DOSE, UP TO 5 MILLICURIES

CY 2005 Code	CY 2005 HCPCS Description	CY 2006 Code	CY 2006 HCPCS Description
C1083	SUPPLY OF RADIOPHARMACEUTICAL THERAPEUTIC IMAGING AGENT, YTTRIUM 90 IBRITUMOMAB TIUXETAN, PER DOSE	A9543	YTTRIUM Y-90 IBRITUMOMAB TIUXETAN, THERAPEUTIC, PER TREATMENT DOSE, UP TO 40 MILLICURIES
C1091	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, INDIUM 111 OXYQUINOLINE, PER 0.5 MILLICURIE	A9547	INDIUM IN-111 OXYQUINOLINE, DIAGNOSTIC, PER 0.5 MILLICURIE
C1092	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, INDIUM 111 PENTETATE, PER 0.5 MILLICURIE	A9548	INDIUM IN-111 PENTETATE, DIAGNOSTIC, PER 0.5 MILLICURIE
C1093	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, TECHNETIUM TC 99M FANOLESOMAB, PER DOSE (10 - 20 MCI)	A9566	TECHNETIUM TC-99M FANOLESOMAB, DIAGNOSTIC, PER STUDY DOSE, UP TO 25 MILLICURIES
C1122	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, TECHNETIUM TC 99M ARCITUMOMAB, PER VIAL	A9549	TECHNETIUM TC-99M ARCITUMOMAB, DIAGNOSTIC, PER STUDY DOSE, UP TO 25 MILLICURIES
C1200	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, TECHNETIUM TC 99M SODIUM GLUCOHEPTONATE, PER VIAL	A9550	TECHNETIUM TC-99M SODIUM GLUCEPTATE, DIAGNOSTIC, PER STUDY DOSE, UP TO 25 MILLICURIE
C1201	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, TECHNETIUM TC 99M SUCCIMER, PER VIAL	A9551	TECHNETIUM TC-99M SUCCIMER, DIAGNOSTIC, PER STUDY DOSE, UP TO 10 MILLICURIES
C1305	GRAFTSKIN, PER 44 SQUARE CENTIMETERS	J7340	DERMAL AND EPIDERMAL, (SUBSTITUTE) TISSUE OF HUMAN ORIGIN, WITH OR WITHOUT BIOENGINEERED OR PROCESSED ELEMENTS, WITH METABOLICALLY ACTIVE ELEMENTS, PER SQUARE CENTIMETER
C1775	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, FLUORODEOXYGLUCOSE F18 (2-DEOXY-2-[18F]FLUORO-D-GLUCOSE), PER DOSE (4-40 MCI/ML)	A9552	FLUORODEOXYGLUCOSE F-18 FDG, DIAGNOSTIC, PER STUDY DOSE, UP TO 45 MILLICURIES

CY 2005 Code	CY 2005 HCPCS Description	CY 2006 Code	CY 2006 HCPCS Description
C9000	INJECTION, SODIUM CHROMATE CR51, PER 0.25 MCI	A9553	CHROMIUM CR-51 SODIUM CHROMATE, DIAGNOSTIC, PER STUDY DOSE, UP TO 250 MICROCURIES
C9007	BACLOFEN INTRATHECAL SCREENING KIT (1 AMP)	J0476	INJECTION, BACLOFEN, 50 MCG FOR INTRATHECAL TRIAL
C9008	BACLOFEN INTRATHECAL REFILL KIT, PER 500 MCG	J0475	INJECTION, BACLOFEN, 10 MG
C9009	BACLOFEN INTRATHECAL REFILL KIT, PER 2000 MCG	J0475	INJECTION, BACLOFEN, 10 MG
C9013	SUPPLY OF CO 57 COBALTOUS CHLORIDE, RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT	A9559	COBALT CO-57 CYANOCOBALAMIN, ORAL, DIAGNOSTIC, PER STUDY DOSE, UP TO 1 MICROCURIE
C9102	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, 51 SODIUM CHROMATE, PER 50 MCI	A9553	CHROMIUM CR-51 SODIUM CHROMATE, DIAGNOSTIC, PER STUDY DOSE, UP TO 250 MICROCURIES
C9103	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, SODIUM IOTHALAMATE I-125 INJECTION, PER 10 UCI	A9554	IODINE I-125 SODIUM IOTHALAMATE, DIAGNOSTIC, PER STUDY DOSE, UP TO 10 MICROCURIES
C9105	INJECTION, HEPATITIS B IMMUNE GLOBULIN, PER 1 ML	90371	HEPATITIS B IMMUNE GLOBULIN, (HBIg), HUMAN, FOR INTRAMUSCULAR USE
C9112	INJECTION, PERFLUTREN LIPID MICROSPHERE, PER 2 ML VIAL	Q9957	INJECTION, PERFLUTREN LIPID MICROSPHERES, PER ML
C9123	HUMAN FIBROBLAST DERIVED TEMPORARY SKIN SUBSTITUTE, PER 247 SQUARE CENTIMETERS	J7344	DERMAL (SUBSTITUTE) TISSUE OF HUMAN ORIGIN, WITH OR WITHOUT OTHER BIOENGINEERED OR PROCESSED ELEMENTS, WITHOUT METABOLICALLY ACTIVE ELEMENTS, PER SQUARE CENTIMETER
C9127	INJECTION, PACLITAXEL PROTEIN-BOUND PARTICLES, PER 1 MG	J9264	INJECTION, PACLITAXEL PROTEIN-BOUND PARTICLES, 1 MG
C9128	INJECTION, PEGAPTANIB SODIUM, PER 0.3 MG	J2503	INJECTION, PEGAPTANIB SODIUM, 0.3 MG
C9129	INJECTION, CLOFARABINE, PER 1 MG	J9027	INJECTION, CLOFARABINE, 1 MG
C9200	BILAYERED CELLULAR MATRIX, PER 36 SQUARE CENTIMETERS	J7340	DERMAL AND EPIDERMAL, (SUBSTITUTE) TISSUE OF HUMAN ORIGIN, WITH OR WITHOUT BIOENGINEERED OR PROCESSED ELEMENTS, WITH METABOLICALLY ACTIVE ELEMENTS, PER SQUARE CENTIMETER

CY 2005 Code	CY 2005 HCPCS Description	CY 2006 Code	CY 2006 HCPCS Description
C9201	HUMAN FIBROBLAST-DERIVED DERMAL SUBSTITUTE, PER 37.5 SQUARE CENTIMETERS	J7342	DERMAL (SUBSTITUTE) TISSUE OF HUMAN ORIGIN, WITH OR WITHOUT OTHER BIOENGINEERED OR PROCESSED ELEMENTS, WITH METABOLICALLY ACTIVE ELEMENTS, PER SQUARE CENTIMETER
C9202	INJECTION, SUSPENSION OF MICROSPHERES OF HUMAN SERUM ALBUMIN WITH OCTAFLUOROPROPANE, PER 3 ML	Q9956	INJECTION, OCTAFLUOROPROPANE MICROSPHERES, PER ML
C9203	INJECTION, PERFLEXANE LIPID MICROSPHERES, PER 10 ML VIAL	Q9955	INJECTION, PERFLEXANE LIPID MICROSPHERES, PER ML
C9205	INJECTION, OXALIPLATIN, PER 5 MG	J9263	INJECTION, OXALIPLATIN, 0.5 MG
C9206	COLLAGEN-GLYCOSAMINOGLYCAN BILAYER MATRIX, PER CM2	J7343	DERMAL AND EPIDERMAL, (SUBSTITUTE) TISSUE OF NON-HUMAN ORIGIN, WITH OR WITHOUT 'OTHER BIOENGINEERED OR PROCESSED ELEMENTS, WITHOUT METABOLICALLY ACTIVE 'ELEMENTS, PER SQUARE CENTIMETER
C9211	INJECTION, ALEFACEPT, FOR INTRAVENOUS USE, PER 7.5 MG	J0215	INJECTION, ALEFACEPT, 0.5 MG
C9212	INJECTION, ALEFACEPT, FOR INTRAMUSCULAR USE, PER 7.5 MG	J0215	INJECTION, ALEFACEPT, 0.5 MG
C9218	INJECTION, AZACITIDINE, PER 1 MG	J9025	INJECTION, AZACITIDINE, 1 MG
C9223	INJECTION, ADENOSINE FOR THERAPEUTIC OR DIAGNOSTIC USE, 6 MG (NOT TO BE USED TO REPORT ANY ADENOSINE PHOSPHATE COMPOUNDS, INSTEAD USE A9270)	J0150	INJECTION, ADENOSINE FOR THERAPEUTIC USE, 6 MG (NOT TO BE USED TO REPORT ANY ADENOSINE PHOSPHATE COMPOUNDS, INSTEAD USE A9270)
C9223	INJECTION, ADENOSINE FOR THERAPEUTIC OR DIAGNOSTIC USE, 6 MG (NOT TO BE USED TO REPORT ANY ADENOSINE PHOSPHATE COMPOUNDS, INSTEAD USE A9270)	J0152	INJECTION, ADENOSINE FOR DIAGNOSTIC USE, 30 MG (NOT TO BE USED TO REPORT ANY ADENOSINE PHOSPHATE COMPOUNDS, INSTEAD USE A9270)
C9226	INJECTION, ZICONOTIDE FOR INTRATHECAL INFUSION, PER 5 MCG	J2278	INJECTION, ZICONOTIDE, 1 MICROGRAM
C9400	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, THALLOUS CHLORIDE TL 201, BRAND NAME, PER MCI	A9505	THALLIUM TL-201 THALLOUS CHLORIDE, DIAGNOSTIC, PER MILLICURIE
C9401	SUPPLY OF THERAPEUTIC RADIOPHARMACEUTICAL, STRONTIUM-89 CHLORIDE, BRAND NAME, PER MCI	A9600	STRONTIUM SR-89 CHLORIDE, THERAPEUTIC, PER MILLICURIE

CY 2005 Code	CY 2005 HCPCS Description	CY 2006 Code	CY 2006 HCPCS Description
C9402	SUPPLY OF RADIOPHARMACEUTICAL THERAPEUTIC IMAGING AGENT, I-131 SODIUM IODIDE CAPSULE, BRAND NAME, PER MCI	A9517	IODINE I-131 SODIUM IODIDE CAPSULE(S), THERAPEUTIC, PER MILLICURIE
C9403	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC AGENT, I-131 SODIUM IODIDE CAPSULE, BRAND NAME, PER MILLICURIE	A9528	IODINE I-131 SODIUM IODIDE CAPSULE(S), DIAGNOSTIC, PER MILLICURIE
C9404	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC AGENT, I-131 SODIUM IODIDE SOLUTION, BRAND NAME, PER MILLICURIE	A9529	IODINE I-131 SODIUM IODIDE SOLUTION, DIAGNOSTIC, PER MILLICURIE
C9405	SUPPLY OF RADIOPHARMACEUTICAL THERAPEUTIC AGENT, I-131 SODIUM IODIDE SOLUTION, BRAND NAME, PER MILLICURIE	A9530	IODINE I-131 SODIUM IODIDE SOLUTION, THERAPEUTIC, PER MILLICURIE
C9410	INJECTION, DEXRAZOXANE HYDROCHLORIDE, BRAND NAME, PER 250 MG	J1190	INJECTION, DEXRAZOXANE HYDROCHLORIDE, PER 250 MG
C9411	INJECTION, PAMIDRONATE DISODIUM, BRAND NAME, PER 30 MG	J2430	INJECTION, PAMIDRONATE DISODIUM, PER 30 MG
C9413	SODIUM HYALURONATE, PER 20 TO 25 MG DOSE FOR INTRA-ARTICULAR INJECTION, BRAND NAME	J7317	SODIUM HYALURONATE, PER 20 TO 25 MG DOSE FOR INTRA-ARTICULAR INJECTION
C9414	ETOPOSIDE, ORAL, BRAND NAME, 50 MG	J8560	ETOPOSIDE; ORAL, 50 MG
C9415	DOXORUBICIN HCL, BRAND NAME, 10 MG	J9000	DOXORUBICIN HCL, 10 MG
C9417	BLEOMYCIN SULFATE, BRAND NAME, 15 UNITS	J9040	BLEOMYCIN SULFATE, 15 UNITS
C9418	CISPLATIN, POWDER OR S0LUTION, BRAND NAME, PER 10 MG	J9060	CISPLATIN, POWDER OR S0LUTION, PER 10 MG
C9419	INJECTION, CLADRIBINE, BRAND NAME, PER 1 MG	J9065	INJECTION, CLADRIBINE, PER 1 MG
C9420	CYCLOPHOSPHAMIDE, BRAND NAME, 100 MG	J9070	CYCLOPHOSPHAMIDE, 100 MG
C9421	CYCLOPHOSPHAMIDE, LYOPHILIZED, BRAND NAME, 100 MG	J9093	CYCLOPHOSPHAMIDE, LYOPHILIZED, 100 MG
C9422	CYTARABINE, BRAND NAME, 100 MG	J9100	CYTARABINE, 100 MG
C9423	DACARBAZINE, BRAND NAME, 100 MG	J9130	DACARBAZINE, 100 MG
C9424	DAUNORUBICIN, BRAND NAME, 10 MG	J9150	DAUNORUBICIN, 10 MG

CY 2005 Code	CY 2005 HCPCS Description	CY 2006 Code	CY 2006 HCPCS Description
C9425	ETOPOSIDE, BRAND NAME, 10 MG	J9181	ETOPOSIDE, 10 MG
C9426	FLOXURIDINE, BRAND NAME, 500 MG	J9200	FLOXURIDINE, 500 MG
C9427	IFOSFAMIDE, BRAND NAME, 1 GM	J9208	IFOSFAMIDE, 1 GM
C9428	MESNA, BRAND NAME, 200 MG	J9209	MESNA, 200 MG
C9429	IDARUBICIN HYDROCHLORIDE, BRAND NAME, 5 MG	J9211	IDARUBICIN HYDROCHLORIDE, 5 MG
C9430	LEUPROLIDE ACETATE, BRAND NAME, PER 1 MG	J9218	LEUPROLIDE ACETATE, PER 1 MG
C9431	PACLITAXEL, BRAND NAME, 30 MG	J9265	PACLITAXEL, 30 MG
C9432	MITOMYCIN, BRAND NAME, 5 MG	J9280	MITOMYCIN, 5 MG
C9433	THIOTEPA, BRAND NAME, 15 MG	J9340	THIOTEPA, 15 MG
C9435	INJECTION, GONADORELIN HYDROCHLORIDE, BRAND NAME, PER 100 MCG	J1620	INJECTION, GONADORELIN HYDROCHLORIDE, PER 100 MCG
C9436	AZATHIOPRINE, PARENTERAL, BRAND NAME, PER 100 MG	J7501	AZATHIOPRINE, PARENTERAL, 100 MG
C9437	CARMUSTINE, BRAND NAME, 100 MG	J9050	CARMUSTINE, 100 MG
C9438	CYCLOSPORINE, ORAL, BRAND NAME, 100 MG	J7502	CYCLOSPORINE, ORAL, 100 MG
C9439	DIETHYLSTILBESTROL DIPHOSPHATE, BRAND NAME, 250 MG	J9165	DIETHYLSTILBESTROL DIPHOSPHATE, 250 MG
C9440	VINORELBINE TARTRATE, BRAND NAME, PER 10 MG	J9390	VINORELBINE TARTRATE, PER 10 MG
J1750	INJECTION, IRON DEXTRAN, 50 MG	J1751	INJECTION, IRON DEXTRAN 165, 50 MG
J1750	INJECTION, IRON DEXTRAN, 50 MG	J1752	INJECTION, IRON DEXTRAN 267, 50 MG
J2324	INJECTION, NESIRITIDE, 0.25 MG	J2325	INJECTION, NESIRITIDE, 0.1 MG
J7051	STERILE SALINE OR WATER, UP TO 5 CC	A4218	STERILE SALINE OR WATER, METERED DOSE DISPENSER, 10 ML
J7350	DERMAL TISSUE OF HUMAN ORIGIN, INJECTABLE, WITH OR WITHOUT OTHER BIOENGINEERED OR PROCESSED ELEMENTS, BUT WITHOUT METABOLIZED ACTIVE ELEMENTS, PER 10 MG	J7350	DERMAL (SUBSTITUTE) TISSUE OF HUMAN ORIGIN, INJECTABLE, WITH OR WITHOUT OTHER BIOENGINEERED OR PROCESSED ELEMENTS, BUT WITHOUT METABOLIZED ACTIVE ELEMENTS, PER 10 MG
Q0136	INJECTION, EPOETIN ALPHA, (FOR NON ESRD USE), PER 1000 UNITS	J0885	INJECTION, EPOETIN ALFA, (FOR NON-ESRD USE), 1000 UNITS
Q0137	INJECTION, DARBEPOETIN ALFA, 1 MCG (NON-ESRD USE)	J0881	INJECTION, DARBEPOETIN ALFA, 1 MICROGRAM (NON-ESRD USE)
Q0187	FACTOR VIIA (COAGULATION FACTOR, RECOMBINANT) PER 1.2 MG	J7189	FACTOR VIIA (ANTIHEMOPHILIC FACTOR, RECOMBINANT), PER 1 MICROGRAM
Q2002	INJECTION, ELLIOTTS B SOLUTION, PER ML	J9175	INJECTION, ELLIOTTS' B SOLUTION, 1 ML
Q2003	INJECTION, APROTININ, 10,000 KIU	J0365	INJECTION, APROTONIN, 10,000 KIU

CY 2005 Code	CY 2005 HCPCS Description	CY 2006 Code	CY 2006 HCPCS Description
Q2005	INJECTION, CORTICORELIN OVINE TRIFLUTATE, PER DOSE	J0795	INJECTION, CORTICORELIN OVINE TRIFLUTATE, 1 MICROGRAM
Q2006	INJECTION, DIGOXIN IMMUNE FAB (OVINE), PER VIAL	J1162	INJECTION, DIGOXIN IMMUNE FAB (OVINE), PER VIAL
Q2007	INJECTION, ETHANOLAMINE OLEATE, 100 MG	J1430	INJECTION, ETHANOLAMINE OLEATE, 100 MG
Q2008	INJECTION, FOMEPIZOLE, 15 MG	J1451	INJECTION, FOMEPIZOLE, 15 MG
Q2011	INJECTION, HEMIN, PER 1 MG	J1640	INJECTION, HEMIN, 1 MG
Q2012	INJECTION, PEGADEMASE BOVINE, 25 IU	J2504	INJECTION, PEGADEMASE BOVINE, 25 IU
Q2013	INJECTION, PENTASTARCH, 10% SOLUTION, PER 100 ML	J2513	INJECTION, PENTASTARCH, 10% SOLUTION, 100 ML
Q2014	INJECTION, SERMORELIN ACETATE, 0.5 MG	Q0515	INJECTION, SERMORELIN ACETATE, 1 MICROGRAM
Q2018	INJECTION, UROFOLLITROPIN, 75 IU	J3355	INJECTION, UROFOLLITROPIN, 75 IU
Q2019	INJECTION, BASILIXIMAB, 20 MG	J0480	INJECTION, BASILIXIMAB, 20 MG
Q2021	INJECTION, LEPIRUDIN, 50 MG	J1945	INJECTION, LEPIRUDIN, 50 MG
Q2022	VON WILLEBRAND FACTOR COMPLEX, HUMAN, PER IU	J7188	INJECTION, VON WILLEBRAND FACTOR COMPLEX, HUMAN, IU
Q3000	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, RUBIDIUM RB-82, PER DOSE	A9555	RUBIDIUM RB-82, DIAGNOSTIC, PER STUDY DOSE, UP TO 60 MILLICURIES
Q3002	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, GALLIUM GA 67, PER MCI	A9556	GALLIUM GA-67 CITRATE, DIAGNOSTIC, PER MILLICURIE
Q3003	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, TECHNETIUM TC99M BICISATE, PER UNIT DOSE	A9557	TECHNETIUM TC-99M BICISATE, DIAGNOSTIC, PER STUDY DOSE, UP TO 25 MILLICURIES
Q3004	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, XENON XE 133, PER 10 MCI	A9558	XENON XE-133 GAS, DIAGNOSTIC, PER 10 MILLICURIES
Q3005	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, TECHNETIUM TC-99M MERTIATIDE, PER MCI	A9562	TECHNETIUM TC-99M MERTIATIDE, DIAGNOSTIC, PER STUDY DOSE, UP TO 15 MILLICURIES
Q3006	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, TECHNETIUM TC 99M GLUCEPATATE, PER 5 MCI	A9550	TECHNETIUM TC-99M SODIUM GLUCEPTATE, DIAGNOSTIC, PER STUDY DOSE, UP TO 25 MILLICURIE
Q3007	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT,	A9563	SODIUM PHOSPHATE P-32, THERAPEUTIC, PER MILLICURIE

CY 2005 Code	CY 2005 HCPCS Description	CY 2006 Code	CY 2006 HCPCS Description
	SODIUM PHOSPHATE P32, PER MCI		
Q3008	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, INDIUM 111-IN PENTETREOTIDE, PER 3 MCI	A9565	INDIUM IN-111 PENTETREOTIDE, DIAGNOSTIC, PER MILLICURIE
Q3009	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, TECHNETIUM TC99M OXIDRONATE, PER MCI	A9561	TECHNETIUM TC-99M OXIDRONATE, DIAGNOSTIC, PER STUDY DOSE, UP TO 30 MILLICURIES
Q3010	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, TECHNETIUM TC99M - LABELED RED BLOOD CELLS, PER MCI	A9560	TECHNETIUM TC-99M LABELED RED BLOOD CELLS, DIAGNOSTIC, PER STUDY DOSE, UP TO 30 MILLICURIES
Q3011	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, CHROMIC PHOSPHATE P32 SUSPENSION, PER MCI	A9564	CHROMIC PHOSPHATE P-32 SUSPENSION, THERAPEUTIC, PER MILLICURIE
Q3012	SUPPLY OF ORAL RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, CYANOCOBALAMIN COBALT CO57, PER 0.5 MCI	A9559	COBALT CO-57 CYANOCOBALAMIN, ORAL, DIAGNOSTIC, PER STUDY DOSE, UP TO 1 MICROCURIE
Q4075	INJECTION, ACYCLOVIR, 5 MG	J0133	INJECTION, ACYCLOVIR, 5 MG
Q4076	INJECTION, DOPAMINE HCL, 40 MG	J1265	INJECTION, DOPAMINE HCL, 40 MG
Q4077	INJECTION, TREPROSTINIL, 1 MG	J3285	INJECTION, TREPROSTINIL, 1 MG
Q9941	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, LYOPHILIZED, 1G	J1566	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, LYOPHILIZED (E.G. POWDER), 500 MG
Q9942	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, LYOPHILIZED, 10 MG	J1566	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, LYOPHILIZED (E.G. POWDER), 500 MG
Q9943	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, NON-LYOPHILIZED, 1G	J1567	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, NON-LYOPHILIZED (E.G. LIQUID), 500 MG
Q9944	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, NON-LYOPHILIZED, 10 MG	J1567	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, NON-LYOPHILIZED (E.G. LIQUID), 500 MG

b. Additional Coding Changes for LOCM, MRI Contrast Agents, and HOCM effective

January 1, 2006

HCPCS codes A4644 [Supply of low osmolar contrast material (100-199 mgs of iodine)], A4645 [Supply of low osmolar contrast material (200-299 mgs of iodine)], and A4646 [Supply of low osmolar contrast material (300-399 mgs of iodine)] that are used to describe low osmolar contrast material (LOCM) will be deleted effective December 31, 2005 and replaced with HCPCS codes Q9945-Q9951 for reporting in the CY 2006 OPPS. The descriptors for the replacement Q-codes for LOCM are listed below:

Table 5: Coding Changes for LOCM

CY 2006 Code	CY 2006 HCPCS Description
Q9945	LOW OSMOLAR CONTRAST MATERIAL, UP TO 149 MG/ML IODINE CONCENTRATION, PER ML
Q9946	LOW OSMOLAR CONTRAST MATERIAL, 150-199 MG/ML IODINE CONCENTRATION, PER ML
Q9947	LOW OSMOLAR CONTRAST MATERIAL, 200-249 MG/ML IODINE CONCENTRATION, PER ML
Q9948	LOW OSMOLAR CONTRAST MATERIAL, 250-299 MG/ML IODINE CONCENTRATION, PER ML
Q9949	LOW OSMOLAR CONTRAST MATERIAL, 300-349 MG/ML IODINE CONCENTRATION, PER ML
Q9950	LOW OSMOLAR CONTRAST MATERIAL, 350-399 MG/ML IODINE CONCENTRATION, PER ML
Q9951	LOW OSMOLAR CONTRAST MATERIAL, 400 OR GREATER MG/ML IODINE CONCENTRATION, PER ML

HCPCS codes A4643 (supply of additional high dose contrast material(s) during magnetic resonance imaging, e.g., gadoteridol injection) and A4647 (supply of paramagnetic contrast material, eg., gadolinium) that are used to describe MRI contrast agents will be deleted effective December 31, 2005 and replaced with HCPCS codes Q9952-Q9954 for reporting in the CY 2006 OPPS. The descriptors for the replacement Q-codes for MRI contrast agents are listed below:

Table 6: Coding Changes for MRI Contrast Agents

CY 2006 Code	CY 2006 HCPCS Description
Q9952	INJECTION, GADOLINIUM-BASED MAGNETIC RESONANCE CONTRAST AGENT, PER ML
Q9953	INJECTION, IRON-BASED MAGNETIC RESONANCE CONTRAST AGENT, PER ML
Q9954	ORAL MAGNETIC RESONANCE CONTRAST AGENT, PER 100 ML

Beginning on January 1, 2006, hospitals can use the HCPCS codes Q9958-Q9964 to bill for high

osmolar contrast material (HOCM) under the OPPS. The descriptors for the new Q-codes for HOCM are listed below:

Table 7: Coding Changes for HOCM

CY 2006 Code	CY 2006 HCPCS Description
Q9958	High osmolar contrast material, up to 149 mg/ml iodine concentration, per ml
Q9959	High osmolar contrast material, 150 - 199 mg/ml iodine concentration, per ml
Q9960	High osmolar contrast material, 200 - 249 mg/ml iodine concentration, per ml
Q9961	High osmolar contrast material, 250 - 299 mg/ml iodine concentration, per ml
Q9962	High osmolar contrast material, 300 - 349 mg/ml iodine concentration, per ml
Q9963	High osmolar contrast material, 350 - 399 mg/ml iodine concentration, per ml
Q9964	High osmolar contrast material, 400 or greater mg/ml iodine concentration, per ml

c. Coding Changes for Sodium Hyaluronan Products

The following HCPCS codes will be effective under the OPPS for sodium hyaluronan products beginning 1/1/06: C9220 (sodium hyaluronate per 30 mg dose, for intra-articular injection), J7317 (sodium hyaluronate per 20 to 25 mg dose for intra-articular injection), and J7320 (Hylan G-F 20, 16 mg, for intra articular injection).

d. Billing for Preadministration-Related Services Associated With Intravenous Immune Globulin Administration

In the CY 2006 hospital outpatient prospective payment system final rule published in the **Federal Register** on November 10, 2005, we announced that we would establish a temporary add-on payment for hospital outpatient departments that administer intravenous immune globulin (IVIG) to Medicare beneficiaries for 2006. This additional payment is for the additional preadministration-related services required to locate and acquire adequate IVIG product and prepare for an infusion of IVIG during this current period where there may be potential market issues.

For dates of service on or after January 1, 2006, and on or before December 31, 2006, Medicare will make a separate payment to hospital outpatient departments for preadministration-related services associated with administration of IVIG. The HCPCS code G0332 has been established to allow providers to bill for this service in CY 2006. This IVIG preadministration service can be billed by the outpatient hospital providing the IVIG infusion only once per patient per day of IVIG administration. The service must be billed on the same claim form as the IVIG product (J1566 and/or J1567) and have the same date of service as the IVIG product and a drug administration service. This IVIG pre-

administration service payment is in addition to Medicare's payments to the hospital for the IVIG product itself and for administration of the IVIG product via intravenous infusion. Below is the coding and payment information for this new service:

Table 8: New Coding Information for Preadministration-Related Services Associated with Intravenous Immune Globulin Administration

HCPCS	Effective Date	SI	APC	Short Descriptor	Long Descriptor	Payment Rate	Minimum Unadjusted Copayment
G0332	01/01/06	S	1502	Preadmin IV immunoglobulin	Services for Intravenous Infusion of Immunoglobulin Prior to Administration, per Infusion Encounter (This service is to be billed in conjunction with administration of immunoglobulin)	$75.00	$15.00

e. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective January 1, 2006

In the CY 2006 OPPS final rule (70 FR 68643), 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, 2006, payment rates for many drugs and biologicals have changed from the values published in the CY 2006 OPPS final rule as a result of the new ASP calculations based on sales price submissions from the third quarter of CY 2005. In cases where adjustments to payment rates are necessary, we will incorporate changes to the payment rates in the January 2006 release of the OPPS PRICER. We are not publishing the updated payment rates in this program instruction implementing the January 2006 update of the OPPS. However, the updated payment rates effective January 1, 2006 can be found in the January 2006 update of the OPPS Addendum A and Addendum B on the CMS Web site.

10. Billing for Intensity Modulated Radiation Therapy

Intensity modulated radiation therapy (IMRT), also known as conformal radiation, delivers radiation with adjusted intensity to preserve adjoining normal tissue. The IMRT has the ability to deliver a higher dose of radiation within the tumor while delivering a lower dose of radiation to surrounding healthy tissue. The IMRT is provided in two treatment phases, planning, and delivery. Two methods by which IMRT can be delivered to patients include multi-leaf collimator-based IMRT and compensator-based IMRT.

Effective January 1, 2006, when IMRT is furnished to beneficiaries in a hospital outpatient department that is paid under the hospital outpatient prospective payment system (OPPS), hospitals are to bill according to the following guidelines:

a. When billing for the planning of IMRT treatment services CPT codes 77280- 77295, 77305 -77321, 77336, and 77370 are not to be billed in addition to 77301; however charges for those services should be included in the charge associated with CPT code 77301.

b. Hospitals are not prohibited from using existing CPT code 77301 to bill for compensator-based IMRT planning in the hospital outpatient setting.

c. As instructed in the 2006 CPT manual, hospitals should bill CPT code 77418 for multi-leaf collimator-based IMRT delivery and Category III CPT code 0073T for compensator-based IMRT delivery in the hospital outpatient setting.

d. Payment for IMRT planning does not include payment for CPT codes 77332 - 77334 when furnished on the same day. When services described by CPT codes 77332-77334 are furnished on the same date of service with 77301, these services are to be billed in addition to the IMRT planning code 77301.

e. Providers billing for both CPT codes 77301 (IMRT treatment planning) and 77334 (design and construction of complex treatment devices) on the same day should append a modifier –59.

11. Billing for Positron Emission Tomography (PET) Scans

As a result of a recent Medicare national coverage decision, Publication 100-03, Medicare National Coverage Determinations Manual, Chapter 1, Part 4, section 220.6, effective January 28, 2005, we discontinued the HCPCS alphanumeric codes with initial letter "G" that had been used to report PET scans (Table 9), and activated the CPT codes listed below in Table 10 for myocardial and nonmyocardial PET scans and concurrent PET/CT scans for anatomical localization. These lists of codes along with claims processing instructions, are provided in Change Request 3756, Transmittal 514, Publication 100-04, Medicare Claims Processing Manual.

Table 9: HCPCS Codes Not Valid for Medicare for Dates of Service on or after January 28, 2005

HCPCS Code	HCPCS Code	HCPCS Code	HCPCS Code
G0030	G0042	G0215	G0228
G0031	G0043	G0216	G0229
G0032	G0044	G0217	G0230
G0033	G0045	G0218	G0231
G0034	G0046	G0220	G0232
G0035	G0047	G0221	G0233
G0036	G0125	G0222	G0234
G0037	G0210	G0223	G0253
G0038	G0211	G0224	G0254
G0039	G0212	G0225	G0296

HCPCS Code	HCPCS Code	HCPCS Code	HCPCS Code
G0040	G0213	G0226	G0336
G0041	G0214	G0227	

Table 10: CPT Codes for Covered PET Scan Indications Effective for Dates of Service on or after January 28, 2005

CPT Code	Description
78459	Myocardial imaging, positron emission tomography (PET), metabolic evaluation
78491	Myocardial imaging, positron emission tomography (PET), perfusion, single study at rest or stress
78492	Myocardial imaging, positron emission tomography (PET), perfusion, multiple studies at rest and/or stress
78608	Brain imaging, positron emission tomography (PET); metabolic evaluation
78811	Tumor imaging, positron emission tomography (PET); limited area (e.g., chest, head/neck)
78812	Tumor imaging, positron emission tomography (PET); skull base to mid thigh
78813	Tumor imaging, positron emission tomography (PET); whole body
78814	Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; limited area (e.g. chest, head/neck)
78815	Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; skull base to mid thigh
78816	Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; whole body

Effective January 28, 2005, hospitals should report the CPT codes listed in Table 10 above for myocardial and nonmyocardial PET scans and concurrent PET/CT scans for anatomical localization delivered in the hospital outpatient setting. In addition, in the CY 2006 OPPS final rule (70 FR 68581) we changed the status indicator for CPT code 78609 (Brain imaging, PET; perfusion evaluation) from "S" (separately paid under the OPPS) to "E" (not paid under the OPPS) retroactive to January 28, 2005, as historically there has been and currently there remains no coverage for this service under the Medicare program.

12. Billing for Stereotactic Radiosurgery

Stereotactic radiosurgery (SRS) is a form of radiation therapy for treating abnormalities, functional disorders, and tumors of the brain, neck, and most recently has expanded to treating tumors of the spine, lung, pancreas, prostate, bone, and liver. There are two basic methods in which SRS can be delivered to patients, linear accelerator-based treatment and multi-source photon-based treatment (often referred to as Cobalt 60). Advances in technology have further distinguished linear accelerator-based SRS therapy into two types: gantry-based systems and image-guided robotic SRS systems. These two types of linear

accelerator-based SRS therapies may be delivered in a complete session or in a fractionated course of therapy up to a maximum of five sessions.

Effective January 1, 2006, we are discontinuing HCPCS codes G0242 and G0338 for the reporting of charges for stereotactic radiosurgery (SRS) planning under the OPPS. Hospitals should bill charges for SRS planning, regardless of the mode of treatment delivery, using all of the available CPT codes that most accurately reflect the services provided.

13. Billing for Wound Care Services

Pursuant to a congressional mandate (Balanced Budget Act of 1997, Pub. L. 105-33) to pay for all therapy services under one prospective payment system, as provided under section 1834(k)(5) of the Act, we created a therapy code list to identify and track outpatient therapy services paid under the Medicare Physician Fee Schedule (MFPS). We provide this list of therapy codes along with their respective designation in the Medicare Claims Processing Manual Pub. 100-04, section 20, chapter 5. We define an "always therapy" service as a service that must be performed by a qualified therapist under a certified therapy plan of care, and a "sometimes therapy" service as a service that may be performed by a non-therapist outside of a certified therapy plan of care.

Effective January 1, 2006, we are reclassifying CPT codes 97602, 97605, and 97606 as "sometimes therapy" services that may be appropriately provided either as therapy or non-therapy services, as well as maintaining our designation of CPT codes 97597 and 97598 as "sometimes therapy" services. In order to pay hospitals accurately when delivering these "sometimes therapy" services independent of a therapy plan of care, we are establishing payment rates for CPT codes 97597, 97598, 97602, 97605, and 97606 under the OPPS when performed as non-therapy services in the hospital outpatient setting. Table 11 below lists the APC assignments and status indicators for these codes when delivered independent of a therapy plan of care in a hospital outpatient setting.

Table 11: CPT Codes for Wound Care Services Paid under the OPPS Effective for Dates of Service on or after January 1, 2006

		CY 2005		CY 2006		
CPT Code	**Descriptor**	**Therapy Designation**	**Status Indicator**	**Therapy Designation**	**APC**	**Status Indicator**
97597	Selective debridement (less than or equal to 20 sq. cm.)	"Sometimes " therapy	A	"Sometimes " therapy	0012	T
97598	Selective debridement (greater than 20 sq. cm.)	"Sometimes " therapy	A	"Sometimes " therapy	0013	T
97602	Non-selective debridement	"Always" therapy	A	"Sometimes " therapy	0340	X

		CY 2005		CY 2006		
CPT Code	**Descriptor**	**Therapy Designation**	**Status Indicator**	**Therapy Designation**	**APC**	**Status Indicator**
97605	Negative pressure wound therapy (less than or equal to 50 sq. cm.)	"Always" therapy	A	"Sometimes " therapy	0012	T
97606	Negative pressure wound therapy (greater than 50 sq. cm.)	"Always" therapy	A	"Sometimes " therapy	0013	T

To further clarify, hospitals will receive separate payment under the OPPS when they bill for wound care services described by CPT codes 97597, 97598, 97602, 97605, and 97606 that are furnished to hospital outpatients by non-therapists independent of a therapy plan of care. In contrast, when such services are performed by a qualified therapist under an approved therapy plan of care, providers should attach an appropriate therapy modifier (that is, GP for physical therapy, GO for occupational therapy, and GN for speech-language pathology) and/or report their charges under a therapy revenue code (that is, 420, 430, or 440) to receive payment under the MPFS. The OCE logic will either assign these services to the appropriate APC for payment under the OPPS if the services are non-therapy, or will direct contractors to the MPFS established payment rates if the services are identified on hospital claims with a therapy modifier or therapy revenue code as therapy.

14. Billing for Therapeutic Apheresis

Services described by CPT codes 36515 (Therapeutic apheresis; with extracorporeal immunoadsorption and plasma reinfusion), 36516 (Therapeutic apheresis; with extracorporeal selective adsorption or selective filtration and plasma reinfusion), and 36522 (Photopheresis, extracorporeal) treat a variety of disorders by modifying or selectively removing agents from the blood and returning that blood to the patient.

In every case, hospitals should report the codes that most accurately describe the service that is furnished. When billing CPT code 36515 to report extracorporeal immunoadsorption treatment and plasma reinfusion with a protein A column for indications such as rheumatoid arthritis and idiopathic thrombocytopenic purpura, hospitals may include the charge for the protein A column in the procedure charge for CPT 36515 or may report the charge separately on a line with an appropriate supply revenue code. Similarly, when billing CPT code 36516 to report extracorporeal selective adsorption or selective filtration and plasma reinfusion for indications such as familial hypercholesterolemia, supply charges may be included either in the procedure charge for CPT code 36516 or reported separately on a line with an appropriate supply revenue code. Lastly, when billing CPT code 36522 to report extracorporeal photopheresis for indications such as cutaneous T cell lymphoma, hospital supply charges may be included in the charge for CPT code 36522 or billed separately on a line with an appropriate supply revenue code. In all cases, payments for the supplies are packaged into the OPPS payments for the apheresis service

15. Billing for Allergy Testing

Providers have expressed confusion related to the reporting of units for allergy testing services described by CPT codes 95004 through 95078. Nine of these CPT codes instruct providers to specify the number of tests or use the singular word "test" in their descriptors, while five of these CPT codes do not contain such an instruction or do not contain "tests" or "testing" in their descriptors. The lack of clarity related to the reporting of units has resulted in erroneous reporting of charges for multiple allergy tests under one unit (that is, "per visit") for the CPT codes that instruct providers to specify the number of tests.

Effective January 1, 2006, we are differentiating single allergy tests ("per test") from multiple allergy tests ("per visit") by assigning these services to two different APCs. We are assigning single allergy tests to newly established APC 0381 and maintaining multiple allergy tests in APC 0370. Hospitals should report charges for the CPT codes that describe single allergy tests (or where CPT instructions direct providers to specify the number of tests) to reflect charges per test rather than per visit and bill the appropriate number of units of these CPT codes to describe all of the tests provided. Table 12 lists the assignment of CPT codes to APCs 0370 and 0381 for CY 2006.

Table 12: Assignment of CPT Codes to APC 0370 and APC 0381 for CY 2006

APC 0370 (Report per encounter)	APC 0381 (Report per test)
95056, Photosensitivity tests	95004, Percutaneous allergy skin tests
95060, Eye allergy tests	95010, Percutaneous allergy titrate test
95078, Provocative testing	95015, Intradermal allergy titrate-drug/bug
95180, Rapid desensitization	95024, Intradermal allergy test, drug/bug
95199U, Unlisted allergy/clinical immunologic service or procedure	95027, Intradermal allergy titrate-airborne
	95028, Intradermal allergy test-delayed type
	95044 Allergy patch tests
	95052 Photo patch test
	95065 Nose allergy test

16. Corrections for the April 2006 Update

The following changes were not made in the January 2006 OPPS OCE and Addendum B but will be implemented in the April 2006 update:

Table 13: HCPCS Deletions, Additions, and Reactivations

HCPCS	Action	Effective Date	Short Descriptor	SI	Edit
G8054	Added	01/01/06	Falls assess not docum 12 mo	M	72
E0590	Deleted	1/1/06			
G0252	Reactivated	4/1/05		E	28
E1239	Reactivated	1/1/06		Y	61

Table 14: Short Descriptor Changes

HCPCS	Old Short Descriptor	New Short Descriptor
J7640	Formorterol injection	Formoterol injection
G8019	Diabetic pt w/LDL> 100mg/dl	Diabetic pt w/LDL>= 100mg/dl
G8020	Diab pt w/LDL<or=100mg/dl	Diab pt w/LDL< 100mg/dl
G8023	DM pt w BP>140/80	DM pt w BP>=140/80

17. 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 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.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4250.1.	Medicare contractors shall install the January 2006 OPPS PRICER.	X	X			X				
4250.2	For those who have not already done so, Medicare contractors shall create a record in the OPSF (**effective January 1, 2005**) for HHAs or Hospices whose OPPS services have been rejected due to not having a CBSA (or special wage index value for providers who qualified for a blended wage index and/or the hold harmless provision). **Note:** CMS is providing a list of HHA and	X	X							

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	Hospice providers on the Pricer PPS web site (http://www.cms.hhs.gov/providers/pricer/default.asp?). Contractors who need to update the CBSA or special wage index in the OPSF for HHA or Hospices, can utilize this list to do so.									
4250.2.1	Medicare contractors should process any HHA and Hospice claims held due to the fact there was not a CBSA or "special wage index" on the OPSF provider record.	X	X							
4250.3	Medicare contractors shall update the OPSF provider records for CY 2006.	X	X							
4250.3.1	Medicare contractors shall enter the CBSA for each provider (as given in Table 1).	X	X							
4250.3.2	When HHA or hospice claims subject to OPPS are suspended for lack of provider wage index information, Medicare contractors shall update the OPSF for providers qualifying for the Section 505 adjustment in CY 2006 and/or the Hold Harmless Provision in CY 2006 by doing the following: 1) Enter a value of "1" in the Special Payment Indicator field, and 2) Enter the final wage index value (given for the provider in Table 1) in the Special Wage Index field. **NOTE:** Although the 505 adjustments is static for each qualifying county for three years, the special wage index will need to be updated (using the final wage index in Table 1) because the post-reclassification CBSA wage index has changed.	X	X							

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4250.3.3	Medicare contractors shall update the OPSF records for providers who received a special wage index in CY 2005, but no longer receive it in CY 2006. For this, contractors will have to do the following: 1) Create a new provider record, effective January 1, 2006, and 2) Enter a blank or "Y" in the special payment indicator field, and 3) Enter zeroes in the special wage index field.	X	X							
4250.4	Medicare contractors shall update their files to accept modifier FB as a valid HCPCS modifier on claims for services provided on or after January 1, 2006.	X	X			X				

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4250. 5	A provider education article related to this instruction will be available at http://new.cms.hhs.gov/MedlearnMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include	X	X							

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 1, 2006 **Implementation Date:** January 3, 2006 **Pre-Implementation Contact(s):** Marina Kushnirova marina.kushnirova@cms.hhs.gov **Post-Implementation Contact(s):** Regional Office	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**