CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1417	**Date: JANUARY 18, 2008**
	Change Request 5912

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

I. SUMMARY OF CHANGES: This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the January 2008 OPPS update. It 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. CMS is re-organizing or deleting information in these sections. These manual revisions will be released in a future CR. The January 2008 Integrated Outpatient Code Editor (I/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.

New / Revised Material
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

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

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N/A	

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
Recurring Update Notification
Unless otherwise specified, the effective date is the date of service.

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 1417	Date: January 18, 2008	Change Request: 5912

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

Effective Date: **January 1, 2008**

Implementation Date: January 7, 2008

I. GENERAL INFORMATION

A. Background: This Recurring Update Notification 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) 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.

January 2008 revisions to I/OCE data files, instructions, and specifications are provided in Change Request (CR) 5865, "January 2008 Integrated Outpatient Code Editor (I/OCE) Specifications Version 9.0."

B. Policy:

1. Payment for Alcohol and/or Substance Abuse Assessment and Intervention Services

For CY 2008, the CPT Editorial Panel has created two new Category I CPT codes for reporting alcohol and/or substance abuse screening and intervention services. They are CPT code 99408 (Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes); and CPT code 99409 (Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes). However, screening services are not covered by Medicare without specific statutory authority, such as has been provided for mammography, diabetes, and colorectal cancer screening. Therefore, for CY 2008 CMS created two parallel Level II HCPCS G-codes (HCPCS codes G0396 and G0397) to allow for appropriate 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.

Contractors shall make payment under the OPPS for HCPCS code G0396 (Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST) and brief intervention, 15 to 30 minutes) and HCPCS code G0397, (Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., 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 Act.

HCPCS codes G0396 and G0397 are to be used for structured alcohol and/or substance (other than tobacco) abuse assessment and intervention services that are distinct from other clinic and emergency department visit services performed during the same encounter. Hospital resources expended performing services described by HCPCS codes G0396 and G0397 may not be counted as resources for determining the level of a visit service and vice versa (i.e., hospitals may not double count the same facility resources in order to reach a higher level clinic or emergency department visit). However, alcohol and/or substance structured assessment or intervention services lasting less than 15 minutes should not be reported using these HCPCS codes, but the hospital resources expended should be included in determining the level of the visit service reported.

2. Payment for Cardiac Rehabilitation Services

The National Coverage Determination for cardiac rehabilitation programs requires that programs must be comprehensive and to be comprehensive they must include a medical evaluation, a program to modify cardiac risk factors (e.g., nutritional counseling), prescribed exercise, education, and counseling. (See the National Coverage Determinations (NCD) Manual, Pub. 100-03, section 20.10.) A cardiac rehabilitation session may include more than one aspect of the comprehensive program. For CY 2008, hospitals will continue to use CPT code 93797 (Physician services for outpatient cardiac rehabilitation, without continuous ECG monitoring (per session)) and CPT code 93798 (Physician services for outpatient cardiac rehabilitation, with continuous ECG monitoring (per session)) to report cardiac rehabilitation services. However, effective with dates of service January 1, 2008 or later, hospitals may report more than one unit of HCPCS codes 93797 or 93798 for a date of service if more than one cardiac rehabilitation session lasting at least 1 hour each is provided on the same day. In order to report more than one session for a given date of service, each session must last a minimum of 60 minutes. For example, if the services provided on a given day total 1 hour and 50 minutes, then only one session should be billed to report the cardiac rehabilitation services provided on that day.

3. Payment for Extended Assessment and Management Composite APCs

Observation services are reported using HCPCS code G0378 (Hospital observation service, per hour). Effective for dates of service on or after January 1, 2008, HCPCS code G0378 for hourly observation services is assigned status indicator N, signifying that its payment is always packaged. No separate payment is made for observation services reported with HCPCS code G0378, and APC 0339 is deleted as of January 1, 2008. In most circumstances, observation services are supportive and ancillary to the other services provided to a patient. In certain circumstances when observation care is provided as an integral part of a patient's extended encounter of care, payment may be made for the entire extended care encounter through one of two composite APCs when certain criteria are met.

APC 8002 (Level I Extended Assessment and Management Composite) describes an encounter for care provided to a patient that includes a high level (Level 5) clinic visit or direct admission to observation in conjunction with observation services of substantial duration (8 or more hours). APC 8003 (Level II Extended Assessment and Management Composite) describes an encounter for care provided to a patient that includes a high level (Level 4 or 5) emergency department visit or critical care services in conjunction with observation services of substantial duration. There is no limitation on diagnosis for payment of these composite APCs; however, composite payment will not be made when observation services are reported in association with a surgical procedure (status indicator T) or the hours of observation care reported are less than 8. The Integrated Outpatient Code Editor (I/OCE) will evaluate every claim received to determine if payment through a composite APC is appropriate. If payment through a composite APC is inappropriate, the I/OCE, in conjunction with the OPPS Pricer, will determine the appropriate status indicator, APC, and payment for every code on a claim.

Table 1-Extended Assessment and Management Composite APCs

Composite APC	Composite APC Title	Criteria for composite payment
8002	Level I Extended Assessment and Management Composite	1) 8 or more units of HCPCS code G0378 are billed-- ● On the same day as HCPCS code G0379; or ● On the same day or the day after CPT codes 99205 or 99215

		and; 2) There is no service with SI=T on the claim on the same date of service or 1 day earlier than G0378
8003	Level II Extended Assessment and Management Composite	1) 8 or more units of HCPCS code G0378 are billed on the same date of service or the date of service after 99284, 99285 or 99291 and; 2) There is no service with SI=T on the claim on the same date of service or 1 day earlier than G0378

All of the following requirements must be met in order for a hospital to receive an APC payment for the extended assessment and management composite APCs:

1. Observation Time
    a. Observation time must be documented in the medical record.
    b. A beneficiary's time in observation (and hospital billing) begins with the beneficiary's admission to an observation bed.
    c. A beneficiary's time in observation (and hospital billing) ends when all clinical or medical interventions have been completed, including follow-up care furnished by hospital staff and physicians that may take place after a physician has ordered the patient be released or admitted as an inpatient.
    d. The number of units reported with HCPCS code G0378 must equal or exceed 8 hours.

2. Additional Hospital Services
    a. The claim for observation services must include one of the following services in addition to the reported observation services. The additional services listed below must have a line item date of service on the same day or the day before the date reported for observation:
        - An emergency department visit (CPT code 99284 or 99285) or
        - A clinic visit (CPT code 99205 or 99215); or
        - Critical care (CPT code 99291); or
        - Direct admission to observation reported with HCPCS code G0379, must be reported on the same date of service as the date reported for observation services.
    b. No procedure with a “T" status indicator can be reported on the same day or day before observation care is provided.
3. Physician Evaluation
    a. The beneficiary must be in the care of a physician during the period of observation, as documented in the medical record by admission, discharge, and other appropriate progress notes that are timed, written, and signed by the physician.

b. The medical record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.

4. Payment for Direct Admission to Observation

For CY 2008, direct admission to observation care continues to be reported using HCPCS code G0379 (Direct admission of patient for hospital observation care). Hospitals should report G0379 when observation services are the result of a direct admission to observation care without an associated emergency room visit, hospital outpatient clinic visit, critical care service, or surgical procedure (T status procedure) on the day of initiation of observation services. Hospitals should only report HCPCS code G0379 when a patient is admitted directly to observation care after being seen by a physician in the community.

Payment for direct admission to observation will be made either separately as a low level hospital clinic visit under APC 604, packaged into payment for composite APC 8002 (Level I Prolonged Assessment and Management Composite), or packaged into payment for other separately payable services provided in the same encounter.

The criteria for payment of HCPCS code G0379 under either APC 8002 or APC 0604 include:

1. Both HCPCS codes G0378 (Hospital observation services, per hr) and G0379 (Direct admission of patient for hospital observation care) are reported with the same date of service.

2. No service with a status indicator of T or V or Critical Care (APC 0617) is provided on the same date of service as HCPCS code G0379.

If either of the above criteria is not met, HCPCS code G0379 will be assigned status indicator N and will be packaged into payment for other separately payable services provided in the same encounter.

5. Changes to Packaged Services for CY 2008 OPPS

Effective for services furnished on or after January 1, 2008, CMS has packaged seven additional categories of HCPCS codes describing ancillary and supportive services, either conditionally or unconditionally, and CMS has created four new composite APCs. Unconditional packaging means payment for a HCPCS code is always packaged. Conditional packaging means payment for a HCPCS code is often packaged, but it may be paid separately under certain circumstances. Composite APCs provide a single payment when more than one of a specified set of major independent services are provided in a single encounter.

Those categories of ancillary and supportive services for which the packaging status is changed for CY 2008 are as follows:

- Guidance services, which are packaged for CY 2008
- Imaging processing services, which are packaged for CY 2008
- Intraoperative services, which are packaged for CY 2008
- Imaging supervision and interpretation services, which are packaged for CY 2008. Certain imaging supervision and interpretation services are always packaged, while others are packaged when the service appears on the same claim with a procedural HCPCS code that has been assigned status indicator T. These codes are T-packaged codes.
- Diagnostic radiopharmaceuticals, which are packaged for CY 2008. In addition, beginning in January 2008, claims for nuclear medicine procedures must contain a code for a diagnostic radiopharmaceutical to be processed to payment.

- Contrast media, which are packaged for CY 2008. Note that CMS has also created new Level II HCPCS C-codes for reporting echocardiography services with contrast beginning in CY 2008.
- Observation services, which are packaged for CY 2008. CMS created two composite APCs, APCs 8002 and 8003, for Extended Assessment and Management, of which observation care is a component. When 8 hours or more of observation care is provided in conjunction with direct admission to observation or a high level clinical or emergency department visit or critical care services, then payment may be made for the extended encounter of care. These Extended Assessment and Management composite APCs may be paid regardless of diagnosis, when the observation care is unrelated to a surgical procedure. I/OCE logic will handle the assignment of these composite APCs for payment.

Table 10 in the CY 2008 OPPS/ASC final rule with comment period contains the HCPCS codes in these categories and the packaging status indicators that apply to them. The tables from the final rule are available in an Excel file on the OPPS Webpage under supporting documentation for the CY 2008 OPPS/ASC final rule.

In addition, effective for services furnished on or after January 1, 2008, low dose rate prostate brachytherapy and cardiac electrophysiology evaluation and ablation will be paid using composite APCs when the claim contains the specified combinations of services. The services that will be paid under composite APCs when the criteria are met are listed in Addenda M of the final rule and are available in an Excel file on the OPPS Webpage under the supporting documentation for this final rule. In these cases, the I/OCE logic will determine the assignment of the composite APCs for payment.

The table below identifies the circumstances, effective January 1, 2008, under which a single composite APC payment will be made for multiple services that meet the criteria for payment through a composite APC. Where the criteria are not met, payment will occur under the usual associated non-composite APC to which the code is assigned. Providers should follow standard coding rules. See Addendum A at www.cms.hhs.gov/HospitalOutpatientPPS/ for the national unadjusted payment rates for these composite APCs.

Table 2-Composite APCs and Criteria for Composite Payment

Composite APC	Composite APC Title	Criteria for Composite Payment
8000	Cardiac Electrophysiologic Evaluation and Ablation Composite	At least one unit of CPT code 93619 or 93620 and at least one unit of CPT code 93650, 93651 or 93652 on the same date of service
8001	Low Dose Rate Prostate Brachytherapy Composite	One or more units of CPT codes 55875 and 77778 on the same date of service
8002	Level I Extended Assessment and Management Composite	1) 8 or more units of HCPCS code G0378 are billed-- ● On the same day as HCPCS code G0379; or ● On the same day or the day after CPT codes 99205 or 99215 and 2) There is no service with SI=T on the claim on the same date of service or 1 day earlier than G0378
8003	Level II Extended Assessment and Management Composite	1) 8 or more units of HCPCS code G0378 are billed on the same date of service or the date of service after 99284, 99285 or 99291 and 2) There is no service with SI=T on the claim

Composite APC	Composite APC Title	Criteria for Composite Payment
		on the same date of service or 1 day earlier than G0378.
0034	Mental Health Services Composite	Payment for any combination of mental health services with the same date of service exceeds the payment for APC 0033. For the list of mental health services to which this composite applies, see the Addendum M in the CY2008 OPPS Final Rule for the pertinent period.

6. Billing for Wound Care Services

In Transmittal 804, Change Request (CR) 4250, issued January 3, 2006, CMS stated that the following CPT codes were classified as "sometimes therapy" services that may be appropriately provided under either a certified therapy plan of care or without a certified therapy plan of care: 97597, Active wound care/20 cm or <; 97598, Active wound care > 20 cm; 97602, Wound(s) care non-selective; 97605, Neg press wound tx, < 50 cm; and 97606, Neg press wound tx, > 50 cm.

CMS further stated that hospitals would 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 individuals independent of a therapy plan of care. In contrast, when such services are performed by a qualified therapist under a certified 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) or report their charges under a therapy revenue code (that is, 0420, 0430, or 0440), or both, to receive payment under the Medicare Physician Fee Schedule (MPFS). The I/OCE logic assigns these services to the appropriate APC for payment under the OPPS if the services are not provided under a certified therapy plan of care or directs 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 services.

Effective January 1, 2008, CMS is revising the list of therapy revenue codes that may be reported with CPT codes 97597, 97598, 97602, 97605, and 97606 to designate them as services that are performed by a qualified therapist under a certified therapy plan of care, and thus payable under the MPFS, to be consistent with the current billing practices of hospitals and to ensure that CMS is making separate payment under the OPPS only in appropriate situations. The list of therapy revenue codes is being revised for reporting these five CPT wound care codes as therapy services to include all revenue codes in the 042X series, which incorporates all revenue codes that begin with 042, such as 0420, 0421, 0422, 0423, 0424, and 0429; the 043X series, which includes all revenue codes that begin with 043, such as 0430, 0431, 0432, 0434, and 0439; and the 044X series, which includes all revenue codes that begin with 044, such as 0440, 0441, 0442, 0443, 0444, and 0449. Therefore, for CY 2008, when services reported with CPT codes 97597, 97598, 97602, 97605, and 97606 are performed by a qualified therapist under a certified 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) or report their charge under a therapy revenue code (that is, 042X,043X, or 044X), or both, to receive payment under the MPFS. Under other circumstances, hospitals would 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 individuals independent of a certified therapy plan of care.

7. Billing for Bone Marrow and Stem Cell Processing Services

Effective January 1, 2008, the three Level II HCPCS codes (G0265, G0266, and G0267) for the special treatment of stem cells prior to transplant will be deleted. Hospitals are required to bill the appropriate CPT

codes, specifically 38207 through 38215, in order to report bone marrow and stem cell processing services under the OPPS.

Table 3-Billing for Bone Marrow and Stem Cell Processing Services

HCPCS Code	CPT Code
G0265	38207
G0266	38208, 38209
G0267	38210, 38211, 38212, 38213, 38214, 38215

8. Billing for Implantable Cardioverter Defibrillators (ICDs)

Effective January 1, 2008, the four Level II HCPCS codes (G0297, G0298, G0299, and G0300) for ICD insertion procedures will be deleted. Hospitals are required to bill the appropriate CPT codes, specifically CPT code 33240 or 33249, as appropriate, along with the applicable device C-codes, for payment under the OPPS.

9. Adjustment to Payment in Cases of Devices Replaced with Partial Credit for the Replaced Device

Effective for services furnished on or after January 1, 2008, hospitals are required to report HCPCS modifier FC on the procedure code for all cases in which the device being implanted is on the list of creditable devices, the procedure code in which the device is used is on the list of creditable APCs, and the hospital receives a credit of 50 percent or more of the cost of the new replacement device. In these cases, Medicare payment will be reduced by 50 percent of the estimated cost of the device included in the APC payment. This policy applies to the same devices to which the no cost or full credit policy applies (see Table 4.1 below). Medicare payment will be reduced by 50 percent of the estimated cost of the device only in cases in which hospitals report the FC modifier for procedures assigned to an APC listed in Table 4.2 below.

Because hospitals may not know at the time the device replacement procedure takes place whether or how much credit the manufacturer will provide for the device, hospitals have the option of either: (1) submitting the claims immediately without the FC modifier and submitting a claim adjustment with the FC modifier at a later date once the credit determination is made; or (2) holding the claim until a determination is made on the level of credit.

Table 4.1—Devices for which the "FC" Modifier Must Be Reported with the Procedure Code when Furnished with Partial Credit for a Replacement Device

Device HCPCS Code	Short Descriptor
C1721	AICD, dual chamber
C1722	AICD, single chamber
C1764	Event recorder, cardiac
C1767	Generator, neurostim, imp
C1771	Rep dev, urinary, w/sling
C1772	Infusion pump, programmable
C1776	Joint device (implantable
C1777	Lead, AICD, endo single coil
C1778	Lead, neurostimulator
C1779	Lead, pmkr, transvenous VDD
C1785	Pmkr, dual, rate-resp
C1786	Pmkr, single, rate-resp
C1813	Prosthesis, penile, inflatab

Device HCPCS Code	Short Descriptor
C1815	Pros, urinary sph, imp
C1820	Generator, neuro rechg bat sys
C1881	Dialysis access system
C1882	AICD, other than sing/dual
C1891	Infusion pump, non-prog, perm
C1895	Lead, AICD, endo dual coil
C1896	Lead, AICD, non sing/dual
C1897	Lead, neurostim, test kit
C1898	Lead, pmkr, other than trans
C1899	Lead, pmkr/AICD combination
C1900	Lead coronary venous
C2619	Pmkr, dual, non rate-resp
C2620	Pmkr, single, non rate-resp
C2621	Pmkr, other than sing/dual
C2622	Prosthesis, penile, non-inf
C2626	Infusion pump, non-prog, temp
C2631	Rep dev, urinary, w/o sling
L8614	Cochlear device/system

Table 4.2—APCs Subject to Adjustment When Billed with Modifier FC

APC	SI	APC Title	CY 2008 FC Modifier Payment Reduction Amount
0039	S	Level I Implantation of Neurostimulator	$4,913.03
0040	S	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve	$1,143.07
0061	S	Laminectomy or Incision for Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve	$1,599.13
0089	T	Insertion/Replacement of Permanent Pacemaker and Electrodes	$2,827.79
0090	T	Insertion/Replacement of Pacemaker Pulse Generator	$2,440.88
0106	T	Insertion/Replacement/Repair of Pacemaker and/or Electrodes	$1,245.41
0107	T	Insertion of Cardioverter-Defibrillator	$9,473.14
0108	T	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	$11,506.07
0222	S	Implantation of Neurological Device	$6,507.68
0225	S	Implantation of Neurostimulator Electrodes, Cranial Nerve	$5,664.61
0227	T	Implantation of Drug Infusion Device	$4,727.90
0259	T	Level VI ENT Procedures	$10,386.58
0315	S	Level II Implantation of Neurostimulator	$7,408.29
0385	S	Level I Prosthetic Urological	$1,373.34

APC	SI	APC Title	CY 2008 FC Modifier Payment Reduction Amount
		Procedures	
0386	S	Level II Prosthetic Urological Procedures	$2,915.99
0418	T	Insertion of Left Ventricular Pacing Elect.	$6,826.23
0625	T	Level IV Vascular Access Procedures	$1,532.90
0654	T	Insertion/Replacement of a permanent dual chamber pacemaker	$2,684.44
0655	T	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker	$3,327.75
0680	S	Insertion of Patient Activated Event Recorders	$1,644.87
0681	T	Knee Arthroplasty	$7,248.15

10. Changes to Device Edits for January 2008

Claims for OPPS services must pass two types of device edits to be accepted for processing: procedure- to-device edits and device-to-procedure edits. Procedure-to device-edits, which have been in place for many procedures since 2005, continue to be in place. These edits require that when a particular procedural HCPCS code is billed, the claim must also contain an appropriate device code.

Since January 1, 2007, CMS also has required that a claim that contains one of a specified set of device codes be returned to the provider if it fails to contain an appropriate procedure code. CMS has determined that the devices contained in this list cannot be correctly reported without one of the specified procedure codes also being reported on the same claim. Where these devices are currently being billed without an appropriate procedure code, the cost of the device is being packaged into the median cost for an incorrect procedure code and therefore is inflating the payment rate for the incorrect procedure code. In addition, hospitals billing devices without the appropriate procedure code, are being incorrectly paid. The device-to-procedure edits are designed to ensure that the costs of these devices are assigned to the appropriate APC in future rate-setting.

Both types of device edits can be found at www.cms.hhs.gov/HospitalOutpatientPPS/ under downloads. Failure to pass these edits will result in the claim being returned to the provider.

11. Payment for Brachytherapy Sources

The Medicare, Medicaid, and SCHIP Extension Act of 2007 requires CMS 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, as noted in the table below). Therefore, the prospective payment rates for each source, which are listed in Addendum B to our CY 2008 final rule dated November 27, 2007, 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, 2008 through June 30, 2008, for payment of brachytherapy sources at hospitals' charges adjusted to their costs. In addition, because of their cost-based payment methodology for the first half of CY 2008, brachytherapy sources will not be eligible for outlier payments or for the rural sole community hospital (SCH) adjustment from January 1 through June 30, 2008. CMS will provide new instructions at a later date for brachytherapy source payment effective July 1, 2008. The codes for separately paid brachytherapy sources, long descriptors, status indicators, and APCs for CY 2008 are listed in Table 5, the comprehensive brachytherapy source table below. Note that when billing for stranded sources, providers should bill the number of units of the appropriate

source HCPCS C-code according to the number of brachytherapy sources in the strand, and should not bill as one unit per strand. See Transmittal 1259, CR 5623, issued June 1, 2007, for further information on billing for brachytherapy sources and the OPPS coding changes made for brachytherapy sources effective July 1, 2007.

Table 5- Comprehensive List of Brachytherapy Sources Payable as of January 1, 2008

CPT/ HCPCS	Long Descriptor	SI	APC
A9527	Iodine I-125, sodium iodide solution, therapeutic, per millicurie	H	2632
C1716	Brachytherapy source, non-stranded, Gold-198, per source	H	1716
C1717	Brachytherapy source, non-stranded, High Dose Rate Iridium-192, per source	H	1717
C1719	Brachytherapy source, non-stranded, Non-High Dose Rate Iridium-192, per source	H	1719
C2616	Brachytherapy source, non-stranded, Yttrium-90, per source	H	2616
C2634	Brachytherapy source, non-stranded, High Activity, Iodine-125, greater than 1.01 mCi (NIST), per source	H	2634
C2635	Brachytherapy source, non-stranded, High Activity, Palladium-103, greater than 2.2 mCi (NIST), per source	H	2635
C2636	Brachytherapy linear source, non-stranded, Palladium-103, per 1MM	H	2636
C2637	Brachytherapy source, non-stranded, Ytterbium-169, per source	B	
C2638	Brachytherapy source, stranded, Iodine-125, per source	H	2638
C2639	Brachytherapy source, non-stranded, Iodine-125, per source	H	2639
C2640	Brachytherapy source, stranded, Palladium-103, per source	H	2640
C2641	Brachytherapy source, non-stranded, Palladium-103, per source	H	2641
C2642	Brachytherapy source, stranded, Cesium-131, per source	H	2642
C2643	Brachytherapy source, non-stranded, Cesium-131, per source	H	2643
C2698	Brachytherapy source, stranded, not otherwise specified, per source	H	2698
C2699	Brachytherapy source, non-stranded, not otherwise specified, per source	H	2699

12. Billing for Drugs, Biologicals, and Radiopharmaceuticals

a. New HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals for CY 2008

Hospitals should 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 used in the care of the patient, as reflected in the longer descriptor of the HCPCS code.

Hospitals are reminded that under the OPPS, if commercially available products are being mixed together to facilitate their concurrent administration, the hospital should report the quantity of each product (reported by HCPCS code) used in the care of the patient. Alternatively, if the hospital is compounding drugs that are not a mixture of commercially available products, but are a different product that has no applicable HCPCS code, then the hospital should report an appropriate unlisted drug

code (J9999 or J3490). In these situations, hospitals are reminded that it is not appropriate to bill HCPCS code C9399. HCPCS code C9399, Unclassified drug or biological, is for new drugs and biologicals that are approved by the FDA on or after January 1, 2004, for which a HCPCS code has not been assigned.

For CY 2008, several new HCPCS codes have been created for reporting drugs and biologicals in the hospital outpatient setting. These codes are listed in Table 6 below.

Table 6- New HCPCS Codes Effective for Certain Drugs, Biologicals, and Radiopharmaceuticals in CY 2008

2008 HCPCS	2008 Short Descriptor	2008 SI	2008 APC
A9501	Tc99m tebroxime	N	
A9509	I123 sodium iodide, dx	N	
A9569	Technetium TC-99m auto WBC	N	
A9570	Indium In-111 auto wbc	N	
A9571	Indium In-111 auto platelet	N	
A9576	Inj prohance multipack	N	
A9577	Inj multihance	N	
A9578	Inj multihance multipack	N	
C9237	Injection, lanreotide acetate	K	9237
C9238	Inj, levetiracetam	K	9238
C9239	Inj, temsirolimus	G	1168
C9240	Injection, ixabepilone	K	9240
C9354	Veritas collagen matrix, cm2	G	9354
C9355	Neuromatrix nerve cuff, cm	G	9355
J0400	Aripiprazole injection	K	1165
J1573	Hepagam B intravenous, inj	K	1138
J2724	Protein C concentrate	K	1139
J9226	Supprelin LA implant	K	1142

Many HCPCS codes for drugs, biologicals, and radiopharmaceuticals have undergone changes in their HCPCS code descriptors that will be effective in CY 2008. In addition, several temporary C-codes have been deleted effective December 31, 2007, and replaced with permanent HCPCS codes in CY 2008. 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 2008 HCPCS codes. The affected HCPCS codes are listed below.

Table 7-HCPCS Code and Dosage Descriptor Changes Effective for Certain Drugs, Biologicals, and Radiopharmaceuticals in CY 2008

CY 2007 HCPCS	CY 2007 Descriptor	CY 2008 HCPCS	CY 2008 Descriptor
C9232	Injection, idursulfase, 1mg	J1743	Injection, idursulfase, 1mg
C9233	Injection, ranibizumab, 0.5 mg	J2778	Injection, ranibizumab, 0.1 mg
C9234	Injection, aglucosidase alfa, 10 mg	J0220	Injection, aglucosidase alfa, 10 mg
C9235	Injection, panitumumab, 10 mg	J9303	Injection, panitumumab, 10 mg
C9236	Injection, eculizumab, 10 mg	J1300	Injection, eculizumab, 10 mg
C9350	Microporous collagen tube of nonhuman origin, per centimeter length	C9352	Microporous collagen implantable tube (Neuragen Nerve Guide), per centimeter length
C9350	Microporous collagen tube of nonhuman origin, per centimeter length	C9353	Microporous collagen implantable slit tube (NeuraWrap Nerve Protector), per centimeter length

CY 2007 HCPCS	CY 2007 Descriptor	CY 2008 HCPCS	CY 2008 Descriptor
C9351	Acellular dermal tissue matrix of nonhuman origin, per square centimeter (Do not report C9351 in conjunction with J7345)	J7348	Dermal (substitute) tissue of nonhuman origin, with or without other bioengineered or processed elements, without metabolically active elements (tissuemend) per square centimeter
C9351	Acellular dermal tissue matrix of nonhuman origin, per square centimeter (Do not report C9351 in conjunction with J7345)	J7349	'Dermal (substitute) tissue of nonhuman origin, with or without other bioengineered or processed elements, without metabolically active elements (primatrix) per square centimeter

b. New HCPCS Drug Codes Separately Payable Under OPPS as of January 1, 2008

The following two HCPCS drug codes will be made effective January 1, 2008. These HCPCS codes will be separately payable under the hospital OPPS. The payment rates for these drugs can be found in the January 2008 update of OPPS Addendum A and Addendum B.

Table 8-New Drug Codes Separately Payable under OPPS as of January 1, 2008

HCPCS Code	APC	SI	Long Descriptor
C9237	9237	K	Injection, lanreotide acetate, 1 mg
C9240	9240	K	Injection, ixabepilone, 1 mg

c. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective January 1, 2008

In the CY 2008 OPPS final rule, 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, 2008, payment rates for many drugs and biologicals have changed from the values published in the CY 2008 OPPS final rule as a result of the new ASP calculations based on sales price submissions from the third quarter of CY 2007. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the January 2008 release of the OPPS PRICER. CMS is not publishing the updated payment rates in this Change request implementing the January 2008 update of the OPPS. However, the updated payment rates effective January 1, 2008, can be found in the January 2008 update of the OPPS Addendum A and Addendum B on the CMS Web site.

d. Updated Payment Rates for Certain HCPCS Codes Effective January 1, 2007 through March 31, 2007

The payment rates for several HCPCS codes were incorrect in the January 2007 OPPS Pricer. The corrected payment rates are listed below and have been installed in the January 2008 OPPS Pricer, effective for services furnished on January 1, 2007, through implementation of the April 2007 update.

Table 9-Updated Payment Rates for Certain HCPCS Codes Effective January 1, 2007 through March 31, 2007

HCPCS Code	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J0152	0917	Adenosine injection	$69.20	$13.84
J0881	1685	Darbepoetin alfa, non-esrd	$3.35	$0.67
J1438	1608	Etanercept injection	$162.08	$32.42
J1440	0728	Filgrastim 300 mcg injection	$190.78	$38.16
J1441	7049	Filgrastim 480 mcg injection	$293.60	$58.72
J2425	1696	Palifermin injection	$11.27	$2.25
J2505	9119	Injection, pegfilgrastim 6mg	$2,142.91	$428.58
J0215	1633	Alefacept	$26.28	$5.26
J0289	0736	Amphotericin b liposome inj	$16.66	$3.33
J1740	9229	Ibandronate sodium injection	$138.85	$27.77
J7342	9054	Metabolically active tissue	$31.66	$6.33
J8560	0802	Etoposide oral 50 MG	$30.53	$6.11
J9268	0844	Pentostatin injection	$1,828.98	$365.80

e. Updated Payment Rates for Selected Drugs and Biologicals Effective April 1, 2007 through June 30, 2007

In the April 2007 OPPS Pricer, the payment rates for several HCPCS codes were incorrect. The corrected payment rates are listed below and have been installed in the January 2008 OPPS Pricer, effective for services furnished on April 1, 2007, through implementation of the July 2007 update.

Table 10-Updated Payment Rates for Selected Drugs and Biologicals Effective April 1, 2007 through June 30, 2007

HCPCS Code	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J0881	1685	Darbepoetin alfa, non-esrd	$3.87	$0.77
J1324	0767	Enfuvirtide injection	$0.38	$0.08
J1438	1608	Etanercept injection	$161.94	$32.39
J1440	0728	Filgrastim 300 mcg injection	$191.60	$38.32
J1441	7049	Filgrastim 480 mcg injection	$295.90	$59.18
J2425	1696	Palifermin injection	$11.38	$2.28
J2505	9119	Injection, pegfilgrastim 6mg	$2,152.12	$430.42

f. Updated Payment Rates for Selected Drugs and Biologicals Effective July 1, 2007 through September 30, 2007

In the July 2007 OPPS Pricer, the payment rates for several HCPCS codes were incorrect. The corrected payment rates are listed below and have been installed in the January 2008 OPPS Pricer, effective for services furnished on July 1, 2007, through implementation of the October 2007 update.

Table 11-Updated Payment Rates for Selected Drugs and Biologicals Effective July 1, 2007 through September 30, 2007

HCPCS Code	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J0881	1685	Darbepoetin alfa, non-esrd	$3.03	$0.61
J1438	1608	Etanercept injection	$163.89	$32.78
J1440	0728	Filgrastim 300 mcg injection	$194.32	$38.86
J1441	7049	Filgrastim 480 mcg injection	$299.99	$60.00
J2505	9119	Injection, pegfilgrastim 6mg	$2,176.29	$435.26
Q3025	9022	IM inj interferon beta 1-a	$116.98	$23.40
Q4089	0945	Rhophylac injection	$5.33	$1.07

g. Correct Reporting of Units for Drugs

Hospitals and providers are reminded to ensure that units of drugs used in the care of 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 6 mg, and 6 mg of the drug was used in the care of the patient, the units billed should be 1. As another example, if the description for the drug code is 50 mg but 200 mg of the drug was used in the care of the patient, the units billed should be 4. 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 used in the care of the patient, hospital should bill 10 units, even though only 1 vial was used. HCPCS short descriptors are limited to 28 characters, including 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 for hospitals to review the complete long descriptors for the applicable HCPCS codes.

h. Payment for Therapeutic Radiopharmaceuticals

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 to our CY 2008 final rule dated November 27, 2007, will not be used for payment during that time period. Instead, the status indicators of therapeutic radiopharmaceutical HCPCS codes which were previously paid at charges adjusted to cost will remain at "H" effective January 1, 2008 through June 30, 2008, for payment of therapeutic radiopharmaceuticals at hospitals' charges adjusted to their costs. The codes for therapeutic radiopharmaceuticals, long descriptors, status indicators and APCs for CY 2008 are listed in Table 12, the comprehensive therapeutic radiopharmaceutical table below.

Table 12- Comprehensive List of Therapeutic Radiopharmaceuticals Payable as of January 1, 2008

CPT/ HCPCS	Long Descriptor	SI	APC
A9517	Iodine I-131 sodium iodide capsule(s), therapeutic, per millicurie	H	1064
A9530	Iodine I-131 sodium iodide solution, therapeutic, per millicurie	H	1150
A9543	Yttrium Y-90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 millicuries	H	1643
A9545	Iodine I-131 tositumomab, therapeutic, per treatment dose	H	1645
A9563	Sodium phosphate P-32, therapeutic, per millicurie	H	1675
A9564	Chromic phosphate P-32 suspension, therapeutic, per millicurie	H	1676
A9600	Strontium Sr-89 chloride, therapeutic, per millicurie	H	0701
A9605	Samarium Sm-153 lexidronamm, therapeutic, per 50 millicuries	H	0702

13. I/OCE Edits for Diagnostic Radiopharmaceuticals

Effective January 1, 2008, the I/OCE will begin editing for the presence of a diagnostic radiopharmaceutical HCPCS code when a separately payable nuclear medicine procedure is present on a claim. Hospitals are required to submit the diagnostic radiopharmaceutical on the same claim as the nuclear medicine procedure. Hospitals are also instructed to submit the claim so that the services on the claim each reflect the date the particular service was provided. Therefore, if the nuclear medicine procedure is provided on a different date of service from a diagnostic radiopharmaceutical, the claim will contain more than one date of service. The nuclear medicine procedure-diagnostic radiopharmaceutical edits are available on the CMS Web site at http://www.cms.hhs.gov/HospitalOutpatientPPS/ under downloads. Failure to pass these edits will result in the claim being returned to the provider.

14. Drug Administration

For CY 2008, hospitals are reminded to use the full set of CPT codes for billing drug administration services provided in the hospital outpatient department setting. This includes new CPT codes for CY 2008 as listed below in table 13. In addition, hospitals are to report all drug administration services, regardless of whether they are separately paid or are packaged.

Table 13– New Drug Administration CPT Codes Effective in CY 2008

CPT Code	Long Descriptor	CY 2008 SI	CY 2008 APC
90769	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to 1 hour, including pump set-up and establishment of subcutaneous infusion site(s)	S	0440
90770	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)	S	0437
90771	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); additional pump set-up with establishment of new subcutaneous infusion site(s) (List	S	0438

	separately in addition to code for primary procedure)		
90776	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); each additional sequential push of the same substance/drug provided in a facility (List separately in addition to code for primary procedure)	N	

15. Billing for Cardiac Echocardiography Services

a. Cardiac Echocardiography Without Contrast

Hospitals are instructed to bill for echocardiograms without contrast in accordance with the CPT code descriptors and guidelines associated with the applicable Level I CPT code(s) (93303-93350).

b. Cardiac Echocardiography With Contrast

Hospitals are instructed to bill for echocardiograms with contrast using the applicable HCPCS code(s) included in table 14 below. Hospitals should also report the appropriate units of the HCPCS codes for the contrast agents used in the performance of the echocardiograms. Codes in Table 14 should be read as either with contrast studies or without followed by with contrast studies. CPT codes should be used for without contrast studies only. In the without contrast followed by with contrast case, hospitals should not bill the CPT code for a without contrast study in addition to the C-code when they provide a without contrast followed by with contrast study.

Table 14 – HCPCS Codes For Echocardiograms With Contrast

HCPCS	Long Descriptor
C8921	Transthoracic echocardiography with contrast for congenital cardiac anomalies; complete
C8922	Transthoracic echocardiography with contrast for congenital cardiac anomalies; follow-up or limited study
C8923	Transthoracic echocardiography with contrast, real-time with image documentation (2D) with or without M-mode recording; complete
C8924	Transthoracic echocardiography with contrast, real-time with image documentation (2D) with or without M-mode recording; follow-up or limited study
C8925	Transesophageal echocardiography (TEE) with contrast, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report
C8926	Transesophageal echocardiography (TEE) with contrast for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report
C8927	Transesophageal echocardiography (TEE) with contrast for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis
C8928	Transthoracic echocardiography with contrast, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report

16. OPPS Outlier Payments

Medicare provides OPPS outlier payments for unusually costly or complex services that separately exceed the fixed-dollar and multiple thresholds. The current and historical outlier thresholds are posted online along with the payment percentage that determines the magnitude of an outlier payment.

CMS is revising the Medicare Claims Processing Manual, Pub 100-04, Chapter 4, Section 10.7, to comport to current OPPS policy. This section will contain a discussion of the changes made since the original policy's implementation, as well as guidelines for outlier payment calculation.

17. Modification of Methodology for Calculation of Hospital Overall Cost-to-Charge Ratio (CCR) for Hospitals that Have Nursing and Paramedical Education Programs

CMS is updating section 10.11.8 of the manual to correct an error in the methodology of the calculation of the hospital overall CCR for hospitals that have nursing and paramedical education programs. Specifically, the instructions for calculating the CCR for cost center 6200, non-distinct unit observation beds are being modified. This is a prospective change that is effective January 1, 2008. It is unnecessary to retroactively re-calculate CCRs that are affected by this instruction.

18. Updating the Outpatient Provider Specific File (Effective January 1, 2008)

For January 1, 2008, contractors shall maintain the accuracy of the provider records in the Outpatient Providers Specific File (OPSF). This includes updating the Core-Based Statistical Area (CBSA) in the provider records, as well as updating the "special wage index" value for those providers who qualify for the 505 adjustment as annotated in Table 15.[1] As always, the IPPS fiscal year 2008 wage index is applied to all hospitals participating in OPPS for the 2008 calendar year.

Contractors shall do the following to update the OPSF (effective January 1, 2008):

1. Update the CBSA value for each provider (as given in Table 15);

2. For providers who qualify for the 505 adjustment in CY 2008;

    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 15) in the Special Wage Index field in the OPSF.

3. For providers who received a special wage index in CY 2007, but no longer receive it in CY 2008;

    a) Create a new provider record, effective January 1, 2008; and

    b) Enter a blank 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 15) because the post-reclassification CBSA wage index has changed.

NOTE: Payment for Distinct Part Units (DPUs) located in an acute care hospital is based on the wage

index for the labor market area where the hospital is located even if the hospital has a reclassified wage index. If the DPU falls in a CBSA eligible to receive the 505 out-migration adjustment, the DPU's final wage index should consist of the geographic wage index plus the appropriate out-migration adjustment.

Table 15- Wage Index by CBSA for NON-IPPS Hospitals that are Eligible for the CBSA Hold Harmless Provision and Section 505 Out-Commuting Adjustment[1]

Provider	CBSA	Section 505 Outcommuting Adjustment	Final Wage Index for Calendar Year
013027	01	YES	0.7701
014009	19460	YES	0.7924
043034	04	YES	0.7552
042007	38220	YES	0.8301
054122	34900	YES	1.414
052034	36084	YES	1.5354
053301	36084	YES	1.5354
054110	36084	YES	1.5354
054020	41884	YES	1.4828
054089	41884	YES	1.4828
054144	41884	YES	1.4828
054003	41884	YES	1.4948
054123	44700	YES	1.1942
054074	46700	YES	1.4604
054141	46700	YES	1.4604
064007	14500	YES	1.0179
063033	22660	YES	0.9733
064016	22660	YES	0.9733
074000	14860	YES	1.2824
074012	14860	YES	1.2824
074014	14860	YES	1.2824
082000	08	YES	1.073
083300	48864	YES	1.073
084001	48864	YES	1.073
084002	48864	YES	1.073
084003	48864	YES	1.073
114018	11	YES	0.8088
134010	13	YES	0.8543
132001	17660	YES	0.9674
154035	15	YES	0.8674
154014	15	YES	0.8762
153040	15	YES	0.8784
154047	15	YES	0.8784
183028	21060	YES	0.8698
184012	21060	YES	0.8698
192050	19	YES	0.7847
193081	19	YES	0.7847
193088	19	YES	0.7847
194085	19	YES	0.7847
194081	19	YES	0.763
193055	19	YES	0.7747
193091	19	YES	0.7671

Provider	CBSA	Section 505 Outcommuting Adjustment	Final Wage Index for Calendar Year
193067	19	YES	0.7687
194075	19	YES	0.7687
194082	19	YES	0.7687
192022	19	YES	0.7647
194065	19	YES	0.7647
194077	19	YES	0.7647
194087	19	YES	0.7647
193058	19	YES	0.7671
193069	19	YES	0.7671
194083	19	YES	0.7671
192034	19	YES	0.7773
193036	19	YES	0.7773
193073	19	YES	0.7773
192036	19	YES	0.7829
192040	19	YES	0.7829
193044	19	YES	0.7829
193063	19	YES	0.7829
193068	19	YES	0.7829
193079	19	YES	0.7829
193047	19	YES	0.7775
193049	19	YES	0.7775
192026	19	YES	0.7973
194047	19	YES	0.7973
214001	12580	YES	1.011
212002	25180	YES	0.9443
214003	25180	YES	0.9443
222000	15764	YES	1.1488
222003	15764	YES	1.1488
222024	15764	YES	1.1488
223026	15764	YES	1.1488
224007	15764	YES	1.1488
224022	15764	YES	1.1488
224038	15764	YES	1.1488
222026	21604	YES	1.0061
222044	21604	YES	1.0061
232034	23	YES	0.9344
234025	23	YES	0.9185
232028	12980	YES	1.01
233025	12980	YES	1.01
234037	12980	YES	1.01
232036	27100	YES	0.9684
232025	35660	YES	0.9235
232023	47644	YES	1.0055
233031	47644	YES	1.0055
234021	47644	YES	1.0055
234024	47644	YES	1.0055
234039	47644	YES	1.0055
232030	47644	YES	1.0059
233028	47644	YES	1.0059

Provider	CBSA	Section 505 Outcommuting Adjustment	Final Wage Index for Calendar Year
234011	47644	YES	1.0059
234023	47644	YES	1.0059
252011	25	YES	0.8198
264027	26	YES	0.824
264005	26	YES	0.824
312018	20764	YES	1.1826
314011	20764	YES	1.1826
313025	35084	YES	1.1942
314010	35084	YES	1.1942
314020	35084	YES	1.1942
313027	45940	YES	1.1709
314013	45940	YES	1.1709
314025	45940	YES	1.1709
324011	32	YES	0.9408
322001	32	YES	0.9595
323025	32	YES	0.9595
323032	29740	YES	0.899
324007	29740	YES	0.899
324009	29740	YES	0.899
324010	29740	YES	0.899
324012	29740	YES	0.899
334017	39100	YES	1.1625
334061	39100	YES	1.1625
344001	39580	YES	0.9678
344011	39580	YES	0.9678
344014	39580	YES	0.9678
362007	36	YES	0.8816
364040	44220	YES	0.8883
372017	37	YES	0.7802
373032	37	YES	0.7802
372019	37	YES	0.8004
384011	38	YES	1.0064
384008	41420	YES	1.0473
392030	39	YES	0.8871
394016	39	YES	0.8361
392034	10900	YES	1.1817
393050	10900	YES	1.1817
392031	27780	YES	0.8342
394020	30140	YES	0.8711
393026	39740	YES	0.9605
394014	39740	YES	0.9605
422004	42	YES	0.8866
423029	11340	YES	0.9317
424011	11340	YES	0.9317
444008	44	YES	0.8283
453089	45	YES	0.8324
454009	45	YES	0.8411
454101	45	YES	0.8265
452018	23104	YES	0.9661

Provider	CBSA	Section 505 Outcommuting Adjustment	Final Wage Index for Calendar Year
452019	23104	YES	0.9661
452028	23104	YES	0.9661
452088	23104	YES	0.9661
453040	23104	YES	0.9661
453041	23104	YES	0.9661
453042	23104	YES	0.9661
453094	23104	YES	0.9661
453300	23104	YES	0.9661
453303	23104	YES	0.9661
454012	23104	YES	0.9661
454019	23104	YES	0.9661
454051	23104	YES	0.9661
454052	23104	YES	0.9661
454061	23104	YES	0.9661
454072	23104	YES	0.9661
454086	23104	YES	0.9661
452041	43300	YES	0.8663
524022	52	YES	0.983
524020	52	YES	0.9877
524021	52	YES	0.9926
522005	39540	YES	0.9879
523026	39540	YES	0.9879

Table 15 includes the list of hospitals paid under the OPPS but not IPPS that were included either in the August 2007 OSCAR file or the October 2007 OPSF that are eligible to receive the 505 out-migration wage adjustment in CY 2008. The CBSA and final wage index are given for each hospital on this list. All other Non-IPPS hospitals not eligible to receive the 505 out-migration adjustment should be paid using the IPPS post-reclassification wage index for their CBSA location.

19. Changes to OPPS PRICER logic

a. Hospitals reclassified for IPPS effective October 1, 2007, will be reclassified for OPPS effective January 1, 2008.

b. Section 401 designations and floor CBSA designations effective October 1, 2007, will be effective for OPPS January 1, 2008.

c. Rural sole community hospitals and essential access community hospitals will continue to receive a 7.1 percent payment increase for most service in CY 2008.

d. New OPPS payment rates and coinsurance amounts will be effective January 1, 2008. All coinsurance rates will be limited to a maximum of 40 percent of the APC payment rate. Coinsurance rates cannot exceed the inpatient deductible of $1,024.

e. For hospital outlier payments under OPPS, there will be no change in the multiple threshold of 1.75 for 2008. 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.

f. However, there will be a change in the fixed dollar threshold in CY 2008. The estimated cost of service must be greater than the APC payment amount plus $1,575 in order to qualify for outlier payments. The previous fixed dollar threshold was $1,825.

g. The charges for services included in a composite payment will be aggregated to one line using Payment Adjustment Flags (PAF) 91-99 for each composite on a claim and considered the total charge for each composite service when determining eligibility for outlier payments.

h. For outliers for Community Mental Health Centers (bill type 76x), there will be no change in the multiple threshold of 3.4 for 2008. This threshold of 3.4 is multiplied by the total line item APC payment to determine eligibility for outlier payments. This multiple amount 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.

i. The OPPS Pricer will continue to respond to claim lines that have a new I/OCE Payment Adjustment Flag (PAF) #7 (Item provided without cost to provider) applied to the line. The OPPS I/OCE will apply the PAF #7 whenever a claim line has a HCPCS on the list of codes subject to this adjustment (as specified in Transmittal 1139, CR 5438, Section B.3, issued December 22, 2006.) and an FB modifier. When OPPS Pricer finds a PAF #7 for a line item, it will apply the offset reduction to offset the device portion from the APC payment, which includes payment for packaged devices. The procedure payment amount remaining after the offset reduction is subject to normal procedure discounting rules. OPPS Pricer will apply the offset to line item payment before applying coinsurance logic so that coinsurance is based on the payment amount remaining after the offset reduction.

j. Effective January 1, 2008, the OPPS Pricer will respond to lines that have a new I/OCE Payment Adjustment Flag (PAF) #8 (i.e., Item provided with partial credit to provider) applied to the line. The OPPS I/OCE will apply the PAF #8 whenever a claim line has a HCPCS on the list of codes subject to this adjustment (as specified in Section I.B.7 of this instruction) and an FC modifier. When OPPS Pricer finds a PAF #8 for a line item, it will apply 50 percent of the dollar offset reduction to offset the device portion from the APC payment, which includes payment for packaged devices. The procedure payment amount remaining after the offset reduction is subject to normal procedure discounting rules. OPPS Pricer will apply the offset to line item payment before applying coinsurance logic so that coinsurance is based on the payment amount remaining after the offset reduction.

20. OCE Logic Change for Partial Hospitalization Program (PHP) Services

Effective January 1, 2008, the Integrated Outpatient Code Editor (I/OCE) will begin using List A and List B as described in Appendix C-a of the CMS Specifications V9.0. List A is a subset of List B and contains only psychotherapy codes, while List B includes all PHP codes. January 2008 revisions to the I/OCE data files, instructions, and specifications are provided in CR 5865.

PHP List A	**PHP List B**
90801	90801
90802	90802
90806	90804
90807	90805

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90809
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90849
90853
90857
90865
90880
90899
96101
96102
96103
96110
96111
96116
96118
96119
96120
G0129
G0176
G0177

21. Coverage Determinations

The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. Fiscal Intermediaries (FIs)/Medicare Administrative Contractors (MACs) determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, FI/MACs determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5912.1	Medicare contractors shall install the January 2008 OPPS Pricer.	X		X		X	X				COBC
5912.2	Medicare contractors shall make payment under the OPPS for HCPCS code G0396 (Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST) and brief intervention, 15 to 30 minutes) and HCPCS code G0397, (Alcohol and/or substance(other than tobacco) abuse structured assessment (e.g., 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 Act.	X		X		X					COBC
5912.3	Effective January 1, 2008, Medicare contractors shall allow payment for more than one session of cardiac rehabilitation services per day.	X		X		X					COBC
5912.4	Effective January 1, 2008, Medicare contractors shall update the list of therapy revenue codes that may be reported with wound care services provided under a certified plan of care to include all revenue codes in the 42x, 43x, and 44x series.	X		X		X	X				COBC
5912.5	Effective January 1, 2008, Medicare contractors shall ensure providers are billing CPT codes: 38207-38215 to report bone marrow and stem cell processing services.	X		X		X					COBC
5912.6	Effective January 1, 2008, Medicare contractors shall ensure providers are billing CPT code 33240 or 33249, as appropriate, to report ICD insertion procedures.	X		X		X					COBC
5912.7	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service that fall on or after January 1, 2007, but prior to April 1, 2007; 2) Contain HCPCS code listed in Table 9; and 3) Were originally processed prior to the installation of the January 2008 OPPS Pricer.	X		X		X					COBC
5912.8	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service that fall on or after April 1, 2007, but prior to July 1, 2007; 2) Contain HCPCS code listed in Table 10; and	X		X		X					COBC

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	3) Were originally processed prior to the installation of the January 2008 OPPS Pricer										
5912.9	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service that fall on or after July 1, 2007, but prior to October 1, 2007; 2) Contain HCPCS code listed in Table 11; and 3) Were originally processed prior to the installation of the January 2008 OPPS Pricer.	X		X		X					COBC
5912.10	Medicare contractors shall return to the provider claims that report a nuclear medicine service but do not also report a diagnostic radiopharmaceutical.	X		X			X				I/OCE COBC
5912.11	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 shall manually add these codes to their systems. Status and payment indicators for these codes will be listed in the January 2008 update of the OPPS Addendum A and Addendum B on the CMS Web site.	X		X		X	X				COBC
5912.12	Medicare contractors shall update the overall CCR to include the costs for cost center 6200 from worksheet D-1 Part IV for all hospitals, including those with nursing and paramedical education programs, at the next scheduled CCR update.	X		X		X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5912.13	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of	X		X		X					COBC

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.										

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
CR 5865	January 2008 Integrated Outpatient Code Editor (I/OCE) Specifications Version 9.0

B. For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Marina Kushnirova at: marina.kushnirova@cms.hhs.gov

Post-Implementation Contact(s): Regional Office

VI. FUNDING

A. *For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC)*:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

B. *For Medicare Administrative Contractors (MAC)*:
The Medicare Administrative Contractor (MAC) is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as changes to the MAC Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.