CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1259	**Date: JUNE 1, 2007**
	Change Request 5623

Subject: July 2007 Update of the Hospital Outpatient Prospective Payment System (OPPS): Summary of Payment Policy Changes

I. SUMMARY OF CHANGES: This Recurring Update Notification describes changes to, and billing instructions for various payment policies implemented in the July 2007 OPPS update. The July 2007 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.

New / Revised Material
Effective Date: July 1, 2007
Implementation Date: July 2, 2007

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
N/A	

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 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: 1259	Date: June 1, 2007	Change Request: 5623

SUBJECT: July 2007 Update of the Hospital Outpatient Prospective Payment System (OPPS): Summary of Payment Policy Changes

Effective Date: **July 1, 2007**

Implementation Date: July 2, 2007

I. GENERAL INFORMATION

A. Background: This Recurring Update Notification describes changes to, and billing instructions for various payment policies implemented in the July 2007 OPPS update. The July 2007 Integrated 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.

July 2007 revisions to I/OCE data files, instructions, and specifications are provided in Change Request (CR) 5617, "July 2007 Integrated Outpatient Code Editor (I/OCE) Specifications Version 8.2."

B. Policy:

1. Changes to Device Edits

The Medicare OPPS procedure to device edits and device to procedure edits are posted on the CMS website at www.cms.hhs.gov/HospitalOutpatientPPS/ under "downloads".

There are no new device to procedure edits for the July 2007 OCE. Therefore, the April 2007 file of device to procedure edits remains unchanged for the July 2007 OCE quarter.

The following new procedure to device edits are being implemented in the July 2007 OCE with the effective dates shown.

Although the device edits for G0392 and G0393, new HCPCS codes for 2007, are effective for services furnished on or after January 1, 2007, no action is required on claims for these services that were processed before the implementation of the July 2007 I/OCE.

Table 1- New Procedure to Device Edits for Implementation in the July 2007 I/OCE

CPT/ HCPCS	SI	Description	2007 APC	Device A	Device A Description	Effective Date of Edit (DOS)	Reason
G0392	T	AV fistula or graft arterial	0081	C1725	Cath, translumin non-laser	1/1/2007	new code for 2007
G0392	T	AV fistula or graft arterial	0081	C1874	Stent, coated/cov	1/1/2007	new code for

CPT/ HCPCS	SI	Description	2007 APC	Device A	Device A Description	Effective Date of Edit (DOS)	Reason
					w/del sys		2007
G0392	T	AV fistula or graft arterial	0081	C1876	Stent, non-coa/non-cov w/del	1/1/2007	new code for 2007
G0392	T	AV fistula or graft arterial	0081	C1885	Cath, translumin angio laser	1/1/2007	new code for 2007
G0392	T	AV fistula or graft arterial	0081	C2625	Stent, non-cor, tem w/del sy	1/1/2007	new code for 2007
G0393	T	AV fistula or graft venous	0081	C1725	Cath, translumin non-laser	1/1/2007	new code for 2007
G0393	T	AV fistula or graft venous	0081	C1874	Stent, coated/cov w/del sys	1/1/2007	new code for 2007
G0393	T	AV fistula or graft venous	0081	C1876	Stent, non-coa/non-cov w/del	1/1/2007	new code for 2007
G0393	T	AV fistula or graft venous	0081	C1885	Cath, translumin angio laser	1/1/2007	new code for 2007
G0393	T	AV fistula or graft venous	0081	C2625	Stent, non-cor, tem w/del sy	1/1/2007	new code for 2007
50688	T	Change of ureter tube	0122	C2625	Stent, non-cor, tem w/ del	10/1/2005	Device added

2. New Services

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

Table 2-New Service Payable as of July 1, 2007

HCPCS	Effective Date	SI	APC	Short Descriptor	Long Descriptor	Payment	Minimum Unadjusted Copayment
C9728	7/1/2007	T	0156	Place device/marker, non pros	Placement of interstitial device(s) for radiation therapy/surgery guidance (eg, fiducial markers, dosimeter), other than prostate (any approach), single or	$209.48	$41.90

					multiple		

3. Category III CPT Codes

The AMA releases Category III CPT codes in January, for implementation beginning the following July, and in July, for implementation beginning the following January. Prior to CY 2006, we implemented new Category III CPT codes once a year in January of the following year.

As discussed in the CY 2006 OPPS final rule with comment period (70 FR 68567), we modified our process for implementing the Category III codes that the AMA releases each January for implementation in July to ensure timely collection of data pertinent to the services described by the codes; to ensure patient access to the services the codes describe; and to eliminate potential redundancy between Category III CPT codes and some of the C-codes that are payable under the OPPS and were created by us in response to applications for new technology services. Therefore, on July 1, 2007, we implemented in the OPPS five Category III CPT codes that the AMA released in January 2007 for implementation in July 2007. The codes, along with their status indicators and APCs, are shown in Table 3 below.

Table 3-Category III CPT Codes Implemented as of July1, 2007

HCPCS Code	Long Descriptor	SI	APC	Payment Rate	Minimum Unadjusted Copayment
0178T	Electrocardiogram, 64 leads or greater, with graphic presentation and analysis; with interpretation and report	B	Not applicable	Not applicable	Not applicable
0179T	Electrocardiogram, 64 leads or greater, with graphic presentation and analysis; tracing and graphics only, without interpretation and report	X	0100	$155.74	$31.15
0180T	Electrocardiogram, 64 leads or greater, with graphic presentation and analysis; interpretation and report only	B	Not applicable	Not applicable	Not applicable
0181T	Corneal hysteresis determination, by air impulse stimulation, bilateral, with interpretation and report	S	0230	$48.55	$9.71
0182T*	High dose rate electronic brachytherapy, per fraction	S	1519	$1,750.00	$350.00

* As indicated by CPT, do not report CPT code 0182T in conjunction with CPT codes 77761-77763, 77776-77778, 77781-77784, 77789. Additionally, when a high dose rate electronic brachytherapy service described by 0182T is provided, along with a procedure to place and remove (if performed) an applicator into the breast for radiation therapy described by HCPCS code C9726, both services are separately reportable.

4. Payment for Brachytherapy Sources

The Medicare Modernization Act of 2003 (MMA) requires us to pay for brachytherapy sources in separately paid APCs, and for the period of January 1, 2004 through December 31, 2006, to pay for brachytherapy sources at hospitals' charges adjusted to their cost. Effective January 1, 2007, we continued to pay for specified brachytherapy sources separately, pursuant to MMA, and at hospitals' charges adjusted to their cost pursuant to the Tax Relief and Health Care Act of 2006, which extends the charges adjusted to cost payment for brachytherapy sources until

January 1, 2008. The Tax Relief and Health Care Act of 2006 also requires that we create separate APC groups for stranded and non-stranded sources furnished on or after July 1, 2007.

We are currently aware of three sources that come in stranded and non-stranded forms: iodine, palladium and cesium. We have therefore created six new codes to reflect these three sources in stranded and non-stranded versions. At the same time, we are deleting the three non-specific brachytherapy source codes for iodine, palladium and cesium. The deleted brachytherapy source codes, effective July 1, 2007, are listed in Table 5 below.

a. Billing for Stranded and Non-stranded Brachytherapy Sources

The new codes for these separately paid sources, long descriptors and APCs are listed in Table 4, the comprehensive brachytherapy source table below, payable as of July 1, 2007. Please 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. If a hospital applies both stranded and non-stranded sources to a patient in a single treatment, the hospital should bill the stranded and non-stranded sources separately, according to the differentiated HCPCS codes listed in Table 4 below.

b. Comprehensive List of Brachytherapy Sources Payable as of July 1, 2007

Below is coding information for all brachytherapy sources payable as of July 1, 2007. Please note that we have added the term "non-stranded" to the descriptors for all sources that are described as "per source," other than iodine-125, palladium-103 and cesium-131, for which we have separate stranded or non-stranded codes. All changes, i.e., new codes and descriptors and changes to existing code descriptors are noted in bold.

Table 4- Comprehensive List of Brachytherapy Sources Payable as of July 1, 2007

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	H	2637
C2638	**Brachytherapy source, stranded, Iodine-125, per source**	**H**	**2638**

CPT/ HCPCS	Long Descriptor	SI	APC
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

c. Coding for Not Otherwise Specified Brachytherapy Sources and New Sources

If we receive information that any of the sources listed above now designated as non-stranded (i.e., other than iodine, palladium and cesium sources) are also FDA-approved and marketed as a stranded source, we will create coding information for the stranded source. We have also established two Not Otherwise Specified codes for stranded and non-stranded sources that are not yet known to us and for which we do not have source-specific codes. If a hospital purchases a new FDA-approved and marketed radioactive source consisting of a radioactive isotope, (consistent with our definition of a brachytherapy source eligible for separate payment, discussed in the November 24, 2006 final rule, 71 FR 68113), for which we do not yet have a separate source code established, the hospital should bill such sources using the appropriate NOS codes found in Table 4 above, i.e., C2698 for stranded NOS sources, and C2699 for non-stranded NOS sources. For example, if a new FDA-approved stranded source comes onto the market and there is currently only a billing code for the non-stranded source, the hospital should bill the stranded source under C2698 (stranded NOS source) until a specific stranded billing code for the source is established.

Hospitals and other parties are invited to submit recommendations to us for new HCPCS codes to describe new sources consisting of a radioactive isotope, including a detailed rationale to support recommended new sources. We will continue to endeavor to add new brachytherapy source codes and descriptors to our systems for payment on a quarterly basis. Please direct such recommendations to the Division of Outpatient care, Mail Stop C4-05-17, Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244.

d. Brachytherapy Source Codes Deleted as of July 1, 2007

We are deleting the following codes for iodine, palladium and cesium sources, effective July 1, 2007, which do not specify whether sources are stranded or non-stranded.

Table 5 - Brachytherapy Source Codes Deleted as of July 1, 2007

CPT/ HCPCS	Long Descriptor
C1718	Brachytherapy source, Iodine-125, per source
C1720	Brachytherapy source, Palladium-103, per source
C2633	Brachytherapy source, Cesium-131, per source

5. Billing for 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 used in the care of the patient.

a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective July 1, 2007

In the CY 2007 OPPS final rule, it was stated that payments for separately payable drugs and biologicals based on average sale prices (ASPs) will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, we will incorporate changes to the payment rates in the July 2007 release of the OPPS PRICER. The updated payment rates effective July 1, 2007, will be included in the July 2007 update of the OPPS Addendum A and Addendum B, which will be posted on the CMS Web site at the end of June.

b. Updated Payment Rates for Certain Drugs and Biologicals Effective January 1, 2007 through March 31, 2007

The payment rates for the drugs and biologicals listed below were incorrect in the April 2007 OPPS PRICER. The corrected payment rates will be installed in the July 2007 OPPS PRICER effective for services furnished on January 1, 2007, through March 31, 2007.

Table 6-Updated Payment Rates for Certain Drugs and Biologicals Effective January 1, 2007 through March 31, 2007

HCPCS	APC	Long Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
C9350	9350	Microporous collagen tube of non-human origin, per centimeter length	$485.91	$97.18
J0152	0917	Injection, adenosine for diagnostic use, 30 mg (not to be used to report any adenosine phosphate compounds; instead use A9270)	$69.20	$13.84
J0215	1633	Injection, alefacept, 0.5 mg	$26.28	$5.26

HCPCS	APC	Long Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J0289	0736	Injection, amphotericin b liposome, 10 mg	$16.66	$3.33
J7342	9054	Dermal (substitute) tissue of human origin, with or without other bioengineered or processed elements, with metabolically active elements, per square centimeter	$31.66	$6.33
J8560	0802	Etoposide; oral, 50 mg	$30.53	$6.11
J9268	0844	Pentostatin, per 10 mg	$1,828.98	$365.80

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

The payment rates for the drugs and biologicals listed below were incorrect in the April 2007 OPPS PRICER. The corrected payment rates will be installed in the July 2007 OPPS PRICER effective for services furnished on April 1, 2007 through June 30, 2007.

Table 7-Updated Payment Rates for Certain Drugs and Biologicals Effective April 1, 2007 through June 30, 2007

HCPCS	APC	Long Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
Q2017	7035	Injection, teniposide, 50 mg	$264.43	$52.89
J2503	1697	Injection, pegaptanib sodium, 0.3 mg	$1107.54	$221.51

d. Newly-Approved Drug Eligible for Pass-Through Status as of July 1, 2007

The following drug has been designated as eligible for pass-through status under the OPPS effective July 1, 2007.

Table 8-Newly-Approved Drug Eligible for Pass-Through Status as of July 1, 2007

HCPCS Code	APC	SI	Long Description
J9261	0825	G	Injection, nelarabine, 50 mg

The payment rate for this drug can be found in the July 2007 update of OPPS Addendum A and Addendum B which will posted on the CMS Web site at the end of June. While this drug code was made effective January 1, 2007, its pass-through status does not become effective until July 1, 2007. J9261 has been assigned to status indicator "K" under the OPPS effective January 1,

2007. However, the status indicator for J9261 will change from "K" to "G" effective July 1, 2007.

e. New HCPCS Drug Codes Separately Payable Under OPPS as of July 1, 2007

The following seven HCPCS drug codes will be made effective July 1, 2007. These HCPCS codes will be separately payable under the hospital OPPS. The payment rates for these drugs can be found in the July 2007 update of OPPS Addendum A and Addendum B which will be posted on the CMS Web site at the end of June.

Table 9-New Drug Codes Separately Payable under OPPS as of July 1, 2007

HCPCS Code	APC	SI	Long Descriptor
Q4087	0943	K	Injection, immune globulin, (Octagam), intravenous, non-lyophilized, (e.g. liquid), 500 mg
Q4088	0944	K	Injection, immune globulin, (Gammagard liquid), intravenous, non-lyophilized, (e.g. liquid), 500 mg
Q4089	0945	K	Injection, rho(d) immune globulin (human), (Rhophylac), intramuscular or intravenous, 100 iu
Q4090	0946	K	Injection, hepatitis b immune globulin (Hepagam B), intramuscular, 0.5 ml
Q4091	0947	K	Injection, immune globulin, (Flebogamma), intravenous, non-lyophilized, (e.g. liquid), 500 mg
Q4092	0948	K	Injection, immune globulin, (Gamunex), intravenous, non-lyophilized, (e.g. liquid), 500 mg
Q4095	0951	K	Injection, zoledronic acid (Reclast), 1 mg

f. Billing for Zometa and Reclast Under OPPS as of July 1, 2007

Effective as of July 1, 2007, two HCPCS codes will exist for zoledronic acid. Hospitals are advised to report HCPCS code J3487 for Zometa and Q4095 for Reclast.

Table 10 – Drug Codes for Zometa and Reclast Under the Hospital OPPS as of July 1, 2007

HCPCS Code	APC	SI	Long Descriptor	Drug Name
J3487	9115	K	Injection, zoledronic acid, 1 mg	Zometa
Q4095	0951	K	Injection, zoledronic acid (Reclast), 1 mg	Reclast

g. Drug HCPCS Code J1567 Not Reportable Under the Hospital OPPS as of July 1, 2007

HCPCS code J1567 will no longer be recognized by Medicare effective July 1, 2007. Therefore, HCPCS code J1567 will no longer be reportable under the hospital OPPS. To report those drugs previously reported under HCPCS code J1567, refer to HCPCS codes Q4087, Q4088, Q4091, or Q4092.

Table 11-Drug Code Not Reportable Under the Hospital OPPS as of July 1, 2007

HCPCS Code	Long Descriptor
J1567	Injection, immune globulin, intravenous, non-lyophilized (e.g. liquid), 500 mg

h. Correct Reporting of Units for Drugs

Hospitals and providers are reminded to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the full HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS descriptor. For example, if the description for the drug code is 6 mg, and 6 mg of the drug was administered to 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 administered to 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 administered to the patient, bill 10 units, even though only 1 vial was administered. 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 to review the complete long descriptors for the applicable HCPCS codes.

6. 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 determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, fiscal intermediaries 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	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5623.1	Medicare contractors shall install the July 2007 OPPS PRICER.	X		X			X	X				
5623.2	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 before April 1, 2007; 2) Contain at least one of the HCPCS codes listed in Table 6; and 3) Were originally processed prior to the installation of the July 2007 OPPS PRICER.	X		X			X					

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5623.3	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 before July 1, 2007; 2) Contain at least one of the HCPCS codes listed in Table 7; and 3) Were previously processed through the April 2007 OPPS PRICER.	X		X			X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5623.4	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 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.	X		X			X					

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:

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 FY 2007 operating budgets.

B. *For Medicare Administrative Contractors (MAC)*:

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). 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.