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Information for Medicare Fee-For-Service Health Care Professionals

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MMA - April 2005 Update of the Hospital Outpatient Prospective Payment System (OPPS): Summary of Payment Policy Changes

Note: This article was updated on February 4, 2013, to reflect current Web addresses. All other information remains unchanged.

Provider Types Affected

Hospitals and other providers submitting claims payable under the OPPS by Medicare Fiscal Intermediaries (FIs)

Provider Action Needed


STOP – Physicians, providers, and suppliers should note that this article is based on information contained in Change Request (CR) 3756, which describes changes to the OPPS to be implemented in the April 2005 OPPS update. CR 3756 further describes changes to, and billing instructions for, various payment policies to be implemented in the April 2005 OPPS update.


CAUTION – Unless otherwise noted, all changes addressed in CR 3756 are effective for services furnished on or after April 1, 2005.


GO – Please see the Background and Additional Information Sections of this instruction for further details regarding these clarifications.

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Background

This article is based on information contained in Change Request (CR) 3756, which describes changes to the OPPS to be implemented in the April 2005 OPPS update.

The April 2005 OPPS Outpatient Code Editor (OCE) and OPPS PRICER will reflect the following:

- The Healthcare Common Procedure Coding System (HCPCS)
- Ambulatory Payment Classification (APC)
- HCPCS Modifier
- Revenue Code additions, changes, and deletions identified in CR3756.

Unless otherwise noted, all changes addressed in CR 3756 are effective for services furnished on or after April 1, 2005. CR 3756 further describes changes to, and billing instructions for, various payment policies to be implemented in the April 2005 OPPS update. Key changes are as follows:

1. New Status Indicator "M"

New Status Indicator "M" was created for services that are not billable to the FI and not payable under the OPPS. Please refer to Attachment A of CR3756 for codes reportable with status indicator "M". (Instructions for accessing CR 3756 will be supplied in the "Additional Information" section of this article.)

2. New Services

The following new services are assigned for payment under the OPPS:

HCPCS	Effective Date	SI	APC	Short Descriptor	Long Descriptor	Payment	Minimum Unadjusted Copayment
C9723	04/01/05	S	1502	Dyn IR Perf Img	Dynamic infrared blood perfusion imaging (DIRI)	$75.00	$15.00
C9724	04/01/05	T	0422	EPS gast cardia plic	Endoscopic full-thickness plication in the gastric cardia using endoscopic plication system (EPS); includes endoscopy	$1335.65	$267.13

3. Clarification of Brachytherapy Source Descriptors

The Centers for Medicare & Medicaid Services (CMS) announced three new brachytherapy sources effective January 1, 2005, in the final rule dated November 15, 2005 and in CR 3632 (Transmittal 423, dated January 6, 2005, subject January 2005 Update of the Hospital Outpatient Prospective Payment System (OPPS): Summary of Payment Policy Changes), which can be found at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R423CP.pdf on the Centers for Medicare and Medicaid Services (CMS) website. Or, you may want to refer to MLN Matters article MM3632, located at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM3632.pdf on the CMS website.

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Two of the brachytherapy source long descriptors, i.e., for C2634 and C2635, are incorrect in Transmittal 423.

The correct descriptors are found in Table 40 of the Code of Federal Regulations November 15, 2005 final rule (42CFR Part 419) which can be found via Government Printing Office (GPO) access in the Federal Register Online: November 15, 2004 (Volume 69, Number 219, page 65841) at the following GPO web site: http://a257.g.akamaitech.net/7/257/2422/06jun20041800/edocket.access.gpo.gov/2004/04-24759.htm. For your convenience, following is a reprint of Table 40:

Table 40. Separately Payable Brachytherapy Sources

HCPCS	Long descriptor	APC	APC title	New status indicator
C1716	Brachytherapy source, Gold 198, per source	1716	Brachytx source, Gold 198.	H
C1717	Brachytherapy source, High Dose Rate Iridium 192, per source.	1717	Brachytx source, HDR Ir-192	H
C1718	Brachytherapy source, Iodine 125, per source.	1718	Brachytx source, Iodine 125.	H
C1719	Brachytherapy source, Non-High Dose Rate Iridium 192, per source.	1719	Brachytx source, Non-HDR Ir-192.	H
C1720	Brachytherapy source, Palladium 103, per source.	1720	Brachytx source, Palladium 103.	H
C2616	Brachytherapy source, Yttrium-90, per source.	2616	Brachytx source, Yttrium-90.	H
C2632*	Brachytherapy solution, Iodine125, per mCi.	2632	Brachytx sol, I-125, per mCi.	H
C2633	Brachytherapy source, Cesium-131, per source.	2633	Brachytx source, Cesium-131.	H
C2634**	Brachytherapy source, High Activity, Iodine-125, greater than 1.01 mCi (NIST), per source.	2634	Brachytx source, HA, I-125.	H
C2635**	Brachytherapy source, High Activity, Palladium-103, greater than 2.2 mCi (NIST), per source.	2635	Brachytx source, HA, P-103.	H
C2636**	Brachytherapy linear source, Palladium-103, per 1MM.	2636	Brachytx linear source, P-103.	H

* Currently paid as a pass-through device category, scheduled to expire from pass-through payment as of January 1, 2005.

** Newly created brachytherapy payment codes beginning January 1, 2005.

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To clarify, CMS is restating the correct long descriptors for C2634 and C2635, as follows:

- C2634 - Brachytherapy Source, High Activity, Iodine-125, greater than 1.01 Mci (NIST), per source
- C2635 - Brachytherapy Source, High Activity, Paladium-103, greater than 2.2 Mci (NIST), per source

All other information for these two sources found in Transmittal 423 is correct and remains the same.

4. Drugs and Biologicals

a. Drugs with Payments Based on Average Sales Price (ASP)

The table below lists the drugs and biologicals whose payments under the OPPS will be established in accordance with the Average Sales Price (ASP) methodology that is used to calculate payment for drugs and biologicals in the physician office setting.

In the 2005 OPPS final rule (69 FR 65777), it was stated that payments for drugs and biologicals based on average sales price (ASP) will be updated on a quarterly basis as later quarter ASP submissions become available.

In cases where adjustments to payment rates are necessary:

- CMS will incorporate changes to the payment rates in an appropriate quarterly release of the OPPS PRICER, and
- CMS will not be publishing the updated payment rates in the program instructions implementing the associated quarterly update of the OPPS.
- CMS will be posting the updated payment rates in the April update of the OPPS Addendum A and Addendum B on the CMS web site.

Single-indication orphan drugs payable under OPPS are also listed below. The methodology used to establish payment rates for these drugs is discussed in the 2005 OPPS final rule (69 FR 219, p 65807) which can be reviews at the following GPO website: *http://a257.g.akamaitech.net/7/257/2422/06jun20041800/edocket.access.gpo.gov/2004/04-24759.htm*.

HCPCS	APC	Long Description
C9123	9123	Human fibroblast derived temporary skin substitute, per 247 square centimeters
C9127	9127	Injection, paclitaxel protein-bound particles, per 1 mg
C9128	9128	Injection, pegaptamib sodium, per 0.3 mg
C9203	9203	Injection, Perflexane lipid microspheres, per single use vial
C9205	9205	Injection, Oxaliplatin, per 5 mg
C9206	9206	Collagen-glycosaminoglycan bilayer matrix, per cm2
C9211	9211	Injection, Alefacept, for intravenous use per 7.5 mg
C9212	9212	Injection , Alefacept, for intramuscular use per 7.5 mg
C9218	9218	Injection, azacitidine, 1 mg

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HCPCS	APC	Long Description
C9220	9220	Sodium hyaluronate per 30 mg dose, for intra-articular injection
C9221	9221	Acellular dermal tissue matrix, per 16cm2
C9222	9222	Decellularized soft tissue scaffold, per 1 cc
J0128	9216	Abarelix for injectable suspension, per 10 mg
J0135	1083	Injection, adalimumab, 20 mg
J0180	9208	Injection, IV, Agalsidase beta, per 1 mg
J0205	0900	Injection, Alglucerase, per 10 units
J0256	0901	Alpha 1 proteinase inhibitor-human, 10 mg
J0595	0703	Injection, Butorphanol tartrate 1 mg
J0878	9124	Injection, daptomycin per 1 mg
J1457	1085	Injection, gallium nitrate, 1 mg
J1785	0916	Injection imiglucerase, per unit
J1931	9209	Injection, laronidase, 0.1 mg
J2185	0729	Injection, meropenem, 100 mg
J2280	1046	Injection, moxifloxacin 100 mg
J2355	7011	Oprelvekin injection, 5 mg
J2357	9300	Injection, omalizumab, per 5 mg
J2469	9210	Injection, palonosetron HCl, 25 mcg
J2783	0738	Injection, rasburicase, 0.5 mg
J2794	9125	Injection, risperidone, long acting, 0.5 mg
J3240	9108	Injection Thyrotropin Alpha , 0.9 mg, provided in 1.1 mg vial
J3411	1049	Injection, Thiamine HCL 100 mg
J3415	1050	Injection, Pyridoxine HCL 100 mg
J3465	1052	Injection, voriconazole, 10 mg
J3486	9204	Injection, Ziprasidone mesylate, per 10 mg
J7308	7308	Aminolevulinic acid HCL for topical administration, 20%, single unit dosage form (354mg)
J7513	1612	Daclizumab, parenteral, 25 mg
J7518	9219	Mycophenolic acid, oral, per 180 mg
J7674	0867	Methacholine chloride administered as inhalation solution through a nebulizer, per 1mg
J9010	9110	Alemtuzumab, 10 mg

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HCPCS	APC	Long Description
J9015	0807	Aldesleukin, per single use vial
J9017	9012	Arsenic trioxide, 1 mg
J9035	9214	Injection, Bevacizumab, per 10 mg
J9041	9207	Injection, Bortezomib, 0.1 mg
J9055	9215	Injection, Cetuximab, per 10 mg
J9160	1084	Denileukin diftitox, 300 mcg
J9216	838	Interferon gamma 1-b, 3 million units
J9300	9004	Gemtuzumab ozogamicin, 5 mg
J9305	9213	Injection, Pemetrexed, per 10 mg
Q2019	1615	Injection, Basiliximab, 20 mg
Q4075	1062	Injection, Acyclovir, 5 mg
Q4076	1070	Injection, Dopamine HCL, 40 mg
Q4077	1082	Injection, Treprostinil, 1 mg
Q4079	9126	Injection, Natalizumab, per 1 mg

b. Updated Payment Rates for Certain Drugs and Biologicals effective January 1, 2005 through March 31, 2005

The payment rates for the drugs, biologicals, and services listed below were incorrect in the January 2005 OPPS PRICER. The corrected payment rates will be installed in the April 2005 OPPS PRICER, effective for services furnished on or after January 1, 2005 through March 31, 2005. Please refer to the CMS web site for these payment rates.

HCPCS	APC	Long Description
C9126	9126	Injection, Natalizumab, per 5 mg
C9222	9222	Decellularized soft tissue scaffold, per 1 cc
J0135	1083	Injection, Adalimumab, 20 mg
J0595	0703	Injection, Butorphanol tartrate 1 mg
J0256	0901	Injection, Alpha 1-Proteinase Inhibitor - Human 10 mg
J0205	0900	Injection, Alglucerase per 10 units
J1785	0916	Injection, Imiglucerase, per unit
J2355	7011	Injection, Oprelvekin, 5 mg
J3240	9108	Injection, Thyrotropin alpha, 0.9 mg
J7513	1612	Daclizumab, parenteral, 25 mg

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J9015	0807	Aldesleukin, per single use vial
J9160	1084	Denileukin diftitox, 300 mcg
J9216	0838	Interferon gamma-1B, 3 million units
J9300	9004	Gemtuzumab ozogamicin, 5 mg
J9017	9012	Arsenic trioxide, 1 mg (Trisenox)
J9010	9110	Alemtuzumab, 10 mg
Q2019	1615	Injection, Basiliximab, 20mg
C9218	9218	Injection, azacitidine, 1 mg
43257	0422	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease
43228	0422	Esophagoscopy, rigid or flexible; with ablation of tumor(s), polyp(s), or other lesion(s), not amendable to removal by hot biopsy forceps, bipolar cautery or snare technique
43830	0422	Gastrostomy, open; without construction of gastric tube (e.g, stamm procedure) (separate procedure)
0008T	0422	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate, with suturing of the esophagogastric junction.
C9724	0422	Endoscopic full-thickness placation in the gastric cardia using endoscopic plication system (EPS); includes endoscopy

c. New HCPCS Codes for Intravenous Immune Globulin (IVIG)

Effective April 1, 2005, the following codes are being added to the Healthcare Common Procedure Coding System (HCPCS) to appropriately distinguish between the lyophilized and non-lyophilized form of IVIG:

HCPCS	SI	APC	Short Descriptor	Long Descriptor
Q9941	K	0869	IVIG lyophil 1g	Injection, Immune Globulin, Intravenous, Lyophilized, 1g
Q9942	K	0870	IVIG lyophil 10 mg	Injection, Immune Globulin, Intravenous, Lyophilized, 10 mg
Q9943	K	0871	IVIG non-lyophil 1g	Injection, Immune Globulin, Intravenous, Non-Lyophilized, 1 mg
Q9944	K	0872	IVIG non-lyophil 10 mg	Injection, Immune Globulin, Intravenous, Non-Lyophilized, 10 mg

Effective for dates of service on or after April 1, 2005, codes J1563 and J1564 will no longer be paid by Medicare; therefore, the status indicator for these codes will be changed to "E". These codes will be replaced with HCPCS codes Q9941 – Q9944 effective April 1, 2005. HCPCS code J1563 has been replaced with Q9941 and Q9943 and J1564 has been replaced with Q9942 and Q9944. OPPS payment for the new Q-codes can be found in the April update of OPPS Addendum A and Addendum B on the CMS Web site, which will be available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html on the CMS website.

d. Billing and Payment for Nesiritide, J2324

Effective January 1, 2005, CMS is correcting the payment rate for J2324, *Injection, Nesiritide, 0.25 mg*.

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HCPCS	SI	APC	Long Descriptor	Payment Rate	Minimum Unadjusted Copayment
J2324	K	9114	Injection, Nesiritide, 0.25 mg	$66.23	$13.25

e. Misclassified Drug: Billing and Payment for Vinorelbine Tartrate, Generic versus Brand Name Form

In the 2005 OPPS final rule, CMS misclassified Vinorelbine Tartrate as a sole source product. Effective January 1, 2005, Vinorelbine Tartrate is reclassified as a multi-source product and is implemented with both a generic and brand name HCPCS code and payment amount. The two HCPCS codes listed in the following table are required under the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) to enable Medicare to differentiate between the payment amounts for an innovator multiple-source (brand name) drug and its non-innovator multiple-source (generic) form. Hospitals should note that the brand name form of Vinorelbine Tartrate should be reported with a new HCPCS code, C9440, which is created effective January 1, 2005.

HCPCS	SI	APC	Short Descriptor	Long Descriptor	Payment Rate	Minimum Unadjusted Copayment	Effective Date
J9390	K	0855	Vinorelbine tartrate/10 mg	Vinorelbine Tartrate, per 10 mg	$52.78	$10.56	01/01/05
C9440	K	9440	Vinorelbine tar, brand	Vinorelbine Tartrate, brand, per 10 mg	$74.84	$14.97	01/01/05

f. New HCPCS Code for Injection, Natalizumab

Hospitals are to report new HCPCS code Q4079, *Injection, Natalizumab, 1 mg* instead of C9126, *Injection, Natalizumab, 5 mg*, when billing for natalizumab furnished on or after April 1, 2005. Q4079 will be assigned to status indicator G beginning April 1, 2005.

g. New HCPCS Code for Adenosine Injection

Effective for services furnished on or after April 1, 2005, hospitals should use HCPCS C9223, *Injection, adenosine for therapeutic or diagnostic use, 6 mg (not to be used to report any adenosine phosphate compounds, instead use A9270)* instead of HCPCS codes J0150, *Injection*, *adenosine, for therapeutic use, 6 mg (not to be used to report any adenosine phosphate compounds, instead use A9270)* and J0152, *Injection, adenosine for diagnostic use, 30 mg (not to be used to report any adenosine phosphate compounds, instead use A9270* Effective April 2005, J0150 and J0152 will be assigned to status indicator "B".

h. Payment for Drugs and Biologicals Recently Approved by the FDA

Transmittal 188 (CR 3287), issued May 28, 2004, explains how hospitals may report new drugs and biologicals after Food and Drug Administration (FDA) approval but before assignment of product-specific HCPCS codes. The MMA requires, beginning in 2004, that payment for new drugs and biologicals after FDA approval but before assignment of product-specific HCPCS codes be equal to 95 percent of Average Wholesale Price (AWP).

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CMS is assigning the following product-specific HCPCS code for billing of two drugs that were approved by the FDA on December 17, 2004 and January 7, 2005, respectively.

HCPCS	SI	APC	Short Descriptor	Long Descriptor	Effective Date of Payment Rate	Payment Rate	Minimum Unadjusted Copayment
C9127	K	9127	Paclitaxel protein pr	Injection, Paclitaxel Protein Bound Particles, per 1 mg	01/07/05	$8.44	$1.69
C9128	K	9128	Inj pegaptamib sodium	Injection, Pegaptiamib Sodium, per 0.3 mg	12/17/04	$1,054.70	$210.94

For claims submitted prior to implementation of the April 2005 OPPS OCE, hospitals may bill for these drugs using HCPCS code C9399, *Unclassified Drug or Biological*, in accordance with CR 3287. For claims submitted on or after implementation of the April 2005 OPPS OCE, hospitals should bill for these drugs using their respective product-specific HCPCS codes.

5. Billing for Venipuncture, Discontinued Code

Effective for services furnished on or after January 1, 2005, HCPCS code G0001, *Routine venipuncture for collection of specimen,* is deleted from the OPPS OCE and discontinued from the HCPCS file. Hospitals paid under the OPPS (12x and 13x bill types) should report HCPCS codes 36415, *Collection of venous blood by venipuncture and* 36416, *Collection of capillary blood specimen (eg, finger, hill, ear stick)*.

6. Billing for Contrast Agents

Hospitals paid under the OPPS should continue reporting contrast agents, as follows:

- A4643, Supply of additional high dose contrast material(s) during magnetic resonance imaging, e.g., gadoteridol injection;
- A4644, Supply of low osmolar contrast material (100-199 mgs of iodine);
- A4645; Supply of low osmolar contrast material (200-299 mgs of iodine);
- A4646, Supply of low osmolar contrast material (300-399 mgs of iodine);
- A4647, Supply of paramagnetic contrast material, e.g., gadolinium;
- C9202, Injection, suspension of microspheres of human serum albumin with octafluoropropane, per 3 ml
- C9203, Injection, perflexane lipid microspheres, per 10 ml vial;
- C9112, Injection, perflutren lipid microsphere, per 2 ml vial

7. Reactivation of OPPS Modifier 27

Modifier -27 was erroneously deleted from the OPPS OCE software effective January 1, 2005. As a result, claims containing modifier -27 will be returned to the provider for services furnished on or after 01/01/2005

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through 03/31/2005. The April OCE release will reactivate modifier -27 effective 01/01/05. In the interim, for claims with dates of service 01/01/05 through 03/31/05, where the provider furnishes additional services that would be reported on the same claim as services related to modifier -27, the provider may wish to remove the charge for the services related to modifier -27 in order to receive payment for the remaining services. In this situation, the provider would submit an adjustment bill in April 2005 upon successful implementation of the OPPS OCE release to receive payment for the services related to modifier -27.

8. Update to Cost-to-Charge ratio (CCR) Threshold

Transmittal A-03-004 (CR 2197) issued January 17, 2003, instructed fiscal intermediaries to use statewide default CCR if the calculated CCR was above 1.604. Since CCR threshold has changed, please refer to Section III for the updated instruction. The statewide default CCRs were updated in the OPPS 2005 Final Rule, published on November 15, 2004.

9. Changes in Billing for Observation Services (APC 0339)

In the transmittal 423 (CR3632), issued on January 6, 2005 (see this transmittal at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R423CP.pdf*) CMS summarized several policy changes related to separate payment of APC 0339 for observation services provided in the hospital outpatient department, in order to simplify billing for hospitals. The changes are effective for services provided on or after January 1, 2005. But, CMS neglected to include as one of the changes the elimination of requirements for specific diagnostic testing. In CR3756, CMS restates the changes of transmittal 423 and adds section 9.a. to include the elimination of requirements for specific diagnostic testing.

a. The current requirements for specific diagnostic testing are removed. The following tests are no longer required to receive payment for APC 0339 (Observation) effective for services provided on or after January 1, 2005:

- For congestive heart failure, a chest x-ray (71010, 71020, 71030), and electrocardiogram (93005) and pulse oximetry (94760, 94761, 94762)
- For asthma, a breathing capacity test (94010) or pulse oximetry (94760, 94761, 94762)
- For chest pain, two sets of cardiac enzyme tests; either two CPK (82550, 82552, 82553) or two troponins (84484, 84512) and two sequential electrocardiograms (93005)

b. The descriptor for HCPCS code G0244 is changed to read: *Observation care provided by a facility to a patient with CHF, chest pain or asthma, minimum 8 hours*. The new descriptor clarifies that separate payment will be made for observation services only when a minimum of 8 hours of care have been provided to the beneficiary. Hospitals should report the number of hours the outpatient is in observation status.

c. To receive separate payment for HCPCS code G0244, hospitals are required to report a qualifying ICD-9-CM diagnosis code for CHF, chest pain or asthma as either the Admitting Diagnosis/Reason for Patient Visit or Principal Diagnosis. The list of ICD-9-CM codes is published in the 2005 OPPS final rule. The code must be reported in the Admitting Diagnosis/Reason for Patient Visit field (form locator 76 or its electronic

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equivalent) or the Principal Diagnosis field (form locator 67 or its electronic equivalent) to qualify for separate payment for observation services.

d. Observation time begins at the clock time documented in the patient's medical record, which coincides with the time the patient is placed in a bed for the purpose of initiating observation care in accordance with a physician's order.

e. The ending time for observation occurs either when the patient is discharged from the hospital or is admitted as an inpatient. The time when a patient is "discharged" from observation status is the clock time when all clinical or medical interventions have been completed, including any necessary follow-up care furnished by hospital staff and physicians that may take place after a physician has ordered that the patient be released or admitted as an inpatient. However, observation care does not include time spent by the patient in the hospital subsequent to the conclusion of therapeutic, clinical, or medical interventions, such as time spent waiting for transportation to go home.

10. Coverage Determinations

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

11. Attachment: Summary of April 2005 Data Changes

Attachment A of CR3756 (see the Additional Information Section at the end of this article for information on viewing CR3756) is the OPPS OCE Summary of Data Changes, effective April 1, 2005. This document summarizes all of the modifications made to APCs, HCPCS and CPT procedure codes, APC assignments, status indicators, modifiers, revenue codes, and edits to update the OPPS OCE for the April 1, 2005 quarterly release.

Your FIs will begin using this OCE and the revised OPPS PRICER on April 4, 2005 and will also take the following actions:

- Mass adjust payment for claims with HCPCS codes listed in item 4.b. above of this article (Updated payment rates for drugs and biologicals effective January 1, 2005), that were (1) incorrectly paid for services furnished on or after January 1, 2005 through March 31, 2005; and (2) processed prior to installation of the April 2005 OPPS PRICER
- Return to providers claims for IVIG services billed with J1563 and J1564 that are submitted after the installation of the April 2005 OPPS OCE. J1563 is replaced with Q9941 and Q9943 and J1564 is replaced with Q9942 and Q9944. These Q- codes shall be reported to Medicare from April 1, 2005 through December 31, 2005. (Note: Q-codes will be deleted December 31, 2005 and replaced with new J-codes effective January 1, 2006.)
- Mass adjust payment for claims with J2324 that were (1) incorrectly paid for services furnished on or after January 1, 2005 through March 31, 2005; and (2) processed prior to installment of the April 2005 OPPS PRICER.

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- Return to providers claims for natalizumab billed with C9126 that are submitted after the installation of the April 2005 OPPS OCE.
- Return to providers claims for adenosine billed with J0150 and J0152 that are submitted after the installation of the April 2005 OPPS OCE.
- Return to providers claims for Injection, Paclitaxel Protein Bound Particles, per 1 mg and Injection, Pegaptiamib Sodium, per 0.3 mg billed with C9399 that are submitted after installation of the April 2005 OPPS OCE.
- Effective with cost reporting periods ending September 30, 2005 or later, Fiscal Intermediaries are instructed to use the statewide default CCR if the calculated CCR is above 1.2. If the calculated CCR is greater than 1.2, enter the applicable statewide average urban or rural hospital default ratio that you currently use to determine CCRs for new providers in the provider's outpatient provider specific file. The statewide default CCRs were updated in the OPPS 2005 Final Rule, published on November 15, 2004

Additional Information

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed by going to http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R514CP.pdf on the CMS website.

If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

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