Medicare Learning Network
MLN Matters®
CMS
Information for Medicare Fee-For-Service Health Care Professionals

MLN Matters Number: MM4250
Related Change Request (CR) #: 4250
Related CR Release Date: January 3, 2006
Effective Date: January 1, 2006
Related CR Transmittal #: 804
Implementation Date: January 3, 2006

January 2006 Update of the Hospital Outpatient Prospective Payment System (OPPS): Summary of Payment Policy Changes and OPPS PRICER Logic Changes

Note: This article was updated on April 3, 2013, to reflect current Web addresses. All other information remains unchanged.

Provider Types Affected

Providers billing Medicare fiscal intermediaries (FIs) and/or regional home health intermediaries (RHHIs) for services subject to the OPPS

Provider Action Needed


STOP – Impact to You

This article is based on Change Request (CR) 4250, which describes changes to, and billing instructions for, various payment policies implemented in the January 2006 OPPS update, and changes to the OPPS PRICER logic.


CAUTION – What You Need to Know

Unless otherwise noted, all changes addressed in CR 4250 are effective for services furnished on or after January 1, 2006.


GO – What You Need to Do

See the *Background* section of this article for further details regarding the January 2006 Update to the hospital OPPS.

Background

Change Request (CR) 4250 describes changes to, and billing instructions for, various payment policies implemented in the January 2006 OPPS update. The

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

January 2006 OPPS Outpatient Code Editor (OCE) and OPPS PRICER reflects additions, changes, and deletions to:

- Healthcare Common Procedure Coding System (HCPCS) codes;
- Ambulatory Payment Classification (APC);
- HCPCS Modifier; and
- Revenue Codes.

CR4250 further describes changes to the OPPS PRICER logic.

January 2006 revisions to OPPS OCE data files, instructions and specifications are provided in Change Request (CR) 4238, "January 2006 Outpatient Prospective Payment System Code Editor (OPPS OCE) Specifications Version 7.0," issued December, 2005. This CR can be found at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R784CP.pdf* on the CMS website. The corresponding MLN Matters article is available at *http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM4238.pdf* on the CMS website. Instructions for drug administration, observation, and intravenous immune globulin (IVIG) will be issued separately.

Changes to the OPPS PRICER Logic

CR4250 makes the following changes to the OPPS PRICER Logic:

- Hospitals reclassified for the Inpatient Prospective Payment System (IPPS) effective October 1, 2005, will be reclassified for OPPS effective January 1, 2006.
- Section 401 designations and floor Metropolitan Statistical Area (MSA) designations effective October 1, 2005, will be effective for OPPS January 1, 2006.
- Rural sole community hospitals will receive a 7.1 percent payment increase in 2006.
- New OPPS payment rates and coinsurance amounts will be effective January 1, 2006. All coinsurance rates will be limited to 40 percent of the APC payment rate. Coinsurance rates cannot exceed the inpatient deductible of $952.
- For hospital outlier payments under OPPS, there will be no change in the multiple threshold of 1.75. This threshold of 1.75 is multiplied by the total line item APC payment to determine eligibility for outlier payments. This factor

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

also is used to determine the outlier payment, which is 50 percent of estimated cost less 1.75 times the APC payment amount.

The payment formula is *(cost – (APC payment x 1.75))/2*.

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

- For outliers for Community Mental Health Centers (CMHCs; bill type 76x), there will be a new multiple threshold of 3.4. The previous threshold was 3.5. The new threshold of 3.4 is multiplied by the total line item APC payment to determine eligibility for outlier payments. This factor is also used to determine the outlier payment, which is 50 percent of estimated costs less 3.4 times the APC payment amount. The payment formula is *(cost – (APC payment x 3.4))/2. CMHC outlier payments are not subject to a fixed dollar threshold.*

New Service

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

Table 1: New Coding Information for Placement and Removal (If Performed) of Applicator into Breast for Radiation Therapy

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

The code is to be used as its descriptor states, for placement or removal (if performed) of an applicator into the breast for radiation therapy. C9726 should be billed when such a service is performed and a more specific CPT or HCPCS code that better describes the service is not available. C9726 does not describe the delivery of radiation therapy or the application or placement of radioactive sources.

New Device Pass-Through Category

The Social Security Act (Section 1833(t)(6)(B), http://www.ssa.gov/OP_Home/ssact/title18/1833.htm) requires that (under the OPPS) categories of devices be eligible for transitional pass-through payments for at least two years, but not more than three years. And, section 1833(t)(6)(B)(ii)(IV) requires that CMS create additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices.

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

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

Table 2: New Device Category Pass-Through Coding Information

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

Device Offset from Payment

The Social Security Act (Section 1833(t)(6)(D)(ii)) requires that CMS deduct from pass-through payments for devices an amount that reflects the portion of the APC payment amount that CMS determines is associated with the cost of the device (70 FR 68627-8).

CMS has determined that it is able to identify the portion of the APC payment amount associated with the cost of the historically utilized device, that is, the non-rechargeable neurostimulator generator implanted through procedures assigned to APC 222, Implantation of Neurological Device, that C1820 would replace.

The device offset from the pass-through payment for C1820 represents the deduction from the pass-through payment for category C1820 that will be made when C1820 is billed with a service assigned to APC 222. Please note that the offset amount from the APC payment is wage adjusted before it is subtracted from the device cost.

Section 1833(t)(6)(D)(ii) of the Social Security Act can be found at *http://www.ssa.gov/OP_Home/ssact/title18/1833.htm* on the Internet.

Revision of Device Category Descriptor for C1767

Section 1833(t)(6)(B)(ii)(IV) of the Social Security Act and 42 CFR 419.66(c)(1) require that CMS establish a new category for a medical device when no existing or previously existing device category is appropriate for the device (67 FR 66781).

In the November 10, 2005 OPPS final rule with comment period for CY 2006 (*http://www.access.gpo.gov/su_docs/fedreg/a051110c.html*), CMS announced that effective January 1, 2006, an additional category will be created for devices that meet all of the criteria required to establish a new category for pass-through

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

payment in instances where CMS believes that an existing or previously existing category descriptor does not appropriately describe the new type of device.

CMS also announced that this may entail the need to clarify or refine the short or long descriptors of the previous category. CMS indicated that each situation will be evaluated on a case-by-case basis using two (2) tests described in the November 10, 2005 final rule with comment period. Any such clarification to a category descriptor will be made prospectively from the date the new category would be made effective (70 FR 68631).

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

Effective January 1, 2006, the revised descriptors for C1767 are the following:

- Revised long descriptor: Generator, neurostimulator (implantable), non-rechargeable
- Revised short descriptor: Generator, neuro non-recharge

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

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

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

Effective for services furnished on or after January 1, 2006, hospitals must report HCPCS modifier -FB with the HCPCS code for a device that was furnished to the hospital without cost to the provider.

For example, when a manufacturer furnishes a replacement device that has been recalled or has failed and that was furnished to the provider without cost to the provider, the hospital must report the modifier -FB with the device code to indicate that the hospital did not incur a cost for the item.

This requirement applies to all HCPCS alphanumeric device codes with initial letter of "C" or "L." Hospitals should submit a token charge (e.g., $1.00) on the line with the device code for the claim to be accepted and processed. If the hospital uses a device that was furnished to it for no cost, but for which the usual cost to the hospital is greater than $50.00 and for which there is no suitable HCPCS

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

alphanumeric code beginning with initial letter of "C" or "L," the hospital must use the modifier -FB with the procedure code for the service in which the device is used.

Modifier -52

Effective for services provided January 1, 2006, a 50 percent reduction will be made for those services to which a -52 modifier is appended. The -52 modifier is used to indicate that a service that did not require anesthesia was partially reduced or discontinued at the physician's discretion.

The physician may discontinue or cancel a procedure that is not completed in its entirety due to a number of circumstances, such as adverse patient reaction or medical judgment that completion of the full study is unnecessary. The modifier is reported most often to identify interrupted or reduced radiological and imaging procedures, and prior to January 1, 2006, policy has been to make full payment for procedures with a -52 modifier.

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

Billing for Drugs, Biologicals, and Radiopharmaceuticals

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

Hospitals are strongly encouraged to report charges for all drugs, biologicals, and radiopharmaceuticals, regardless of whether the items are paid separately or packaged, using the correct HCPCS codes for the items used. Also important is that hospitals billing for these products ensure that the reported units of service of the reported HCPCS code are consistent with the quantity of a drug, biological, or radiopharmaceutical that was actually administered to the patient.

For CY 2006, many HCPCS codes for drugs, biologicals, and radiopharmaceuticals have undergone changes in their HCPCS code descriptors. In addition, many temporary C-codes and Q-codes have also been discontinued effective December 31, 2005, and replaced with permanent HCPCS codes in CY 2006.

Hospitals should pay close attention to accurate billing for units of service consistent with the dosages contained in the new long descriptors of the active CY 2006 HCPCS codes. The affected HCPCS codes are listed in Table 4 of CR4250 ("New HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals").

Due to its length, Table 4 is not included in this article, but it can be reviewed in CR4250, which can be found at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R786CP.pdf* on the CMS website.

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Additional Coding Changes for LOCM, MRI Contrast Agents, and HOCM effective January 1, 2006

The following HCPCS codes that are used to describe low osmolar contrast material (LOCM) will be discontinued effective December 31, 2005:

- A4644 [Supply of low osmolar contrast material (100-199 mgs of iodine)];
- A4645 [Supply of low osmolar contrast material (200-299 mgs of iodine)]; and
- A4646 [Supply of low osmolar contrast material (300-399 mgs of iodine)]

They are replaced with HCPCS codes Q9945-Q9951 for reporting in the CY 2006 OPPS. The descriptors for the replacement Q-codes for LOCM are listed below:

Table 3: Coding Changes for LOCM

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

HCPCS codes A4643 (Supply of additional high dose contrast material(s) during magnetic resonance imaging, e.g., gadoteridol injection) and A4647 (Supply of paramagnetic contrast material, e.g., gadolinium) that are used to describe MRI contrast agents will be discontinued effective December 31, 2005 and replaced with HCPCS codes Q9952-Q9954 for reporting in the CY 2006 OPPS. The descriptors for the replacement Q-codes for MRI contrast agents are listed in Table 4 below.

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Table 4: Coding Changes for MRI Contrast Agents

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

Beginning on January 1, 2006, hospitals can use the HCPCS codes Q9958-Q9964 to bill for high osmolar contrast material (HOCM) under the OPPS. The descriptors for the new Q-codes for HOCM are listed in Table 5 below.

Table 5: Coding Changes for HOCM

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

Coding for Sodium Hyaluronan Products

In CY 2006, hospitals must use the following HCPCS codes to bill for sodium hyaluronan products under the OPPS:

- C9220 (Sodium hyaluronate per 30 mg dose, for intra-articular injection);
- J7317 (Sodium hyaluronate per 20 to 25 mg dose for intra-articular injection); and
- J7320 (Hylan G-F 20, 16 mg, for intra-articular injection).

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

In the CY 2006 hospital OPPS final rule published in the *Federal Register* on November 10, 2005, (http://www.access.gpo.gov/su_docs/fedreg/a051110c.html), CMS announced that they would establish a temporary add-on payment for hospital outpatient departments that administer intravenous immune globulin (IVIG) to Medicare beneficiaries for 2006.

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

This additional payment is for the additional preadministration-related services required to locate and acquire adequate IVIG product and prepare for an infusion of IVIG during this current period where there may be potential market issues.

For dates of service on or after January 1, 2006, and on or before December 31, 2006, Medicare will make a separate payment to hospital outpatient departments for preadministration-related services associated with the administration of IVIG. HCPCS code G0332 has been established to allow providers to bill for this service in CY 2006.

This IVIG preadministration service can be billed by the outpatient hospital providing the IVIG infusion only once per patient per day of IVIG administration. The service must be billed on the same claim form as the IVIG product (J1566 and/or J1567) and have the same date of service as the IVIG product and a drug administration service.

This IVIG pre-administration service payment is in addition to Medicare's payments to the hospital for the IVIG product itself and for administration of the IVIG product via intravenous infusion. The coding and payment information for this new service is shown in Table 6 below.

Table 6: New Coding Information for Preadministration-Related Services Associated with Intravenous Immune Globulin Administration

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

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

The CY 2006 OPPS final rule (70 FR 68643, http://www.access.gpo.gov/su_docs/fedreg/a051110c.html) stated that payments for drugs and biologicals based on average sale prices (ASPs) will be updated on a quarterly basis as later quarter ASP submissions become available.

Effective January 1, 2006, payment rates for many drugs and biologicals have changed from the values published in the CY 2006 OPPS final rule as a result of the new ASP calculations based on sales price submissions from the third quarter of CY 2005.

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

In cases where adjustments to payment rates are necessary, CMS will incorporate changes to the payment rates in the January 2006 release of the OPPS PRICER. CMS is not publishing the updated payment rates in this article instruction implementing the January 2006 update of the OPPS.

However, the updated payment rates effective January 1, 2006 can be found in the January 2006 update of the OPPS Addendum A and Addendum B at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html* on the CMS website.

Coding and Payment Changes for Administration of Hepatitis B Vaccine

Effective for services furnished on or after January 1, 2006, providers paid under the OPPS—hospitals (bill types 12x and 13X) and home health agencies (bill type 34X)—should use the following CPT codes to report administration of hepatitis B vaccine:

- 90471, *Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid);* or
- 90472, *Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (as appropriate)*.

In CY 2006, CPT codes 90471 and 90472 map to APC 0353 (Injection, Level II) for payment under the OPPS. (Beginning in CY 2006, payment for hepatitis B vaccine is made on a reasonable cost basis to providers paid under the OPPS.)

Providers paid under the OPPS should discontinue use of HCPCS code G0010, *Administration of hepatitis B vaccine,* effective for services furnished on or after January 1, 2006.

Billing for Intensity Modulated Radiation Therapy

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

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

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

- When billing for the planning of IMRT treatment services, CPT codes 77280 through 77295, 77305 through 77321, 77336, and 77370 are not to be billed in addition to 77301; however, charges for those services should be included in the charge associated with CPT code 77301.
- Hospitals are not prohibited from using existing CPT code 77301 to bill for compensator-based IMRT planning in the hospital outpatient setting.
- As instructed in the 2006 CPT manual, hospitals should bill CPT code 77418 for multi-leaf collimator-based IMRT delivery and Category III CPT code 0073T for compensator-based IMRT delivery in the hospital outpatient setting.
- Payment for IMRT planning does not include payment for CPT codes 77332 - 77334 when furnished on the same day. When provided, these services are to be billed in addition to the IMRT planning code 77301.
- Providers billing for both CPT codes 77301 (IMRT treatment planning) and 77334 (design and construction of complex treatment devices) on the same day should append a modifier –59.

Billing for Positron Emission Tomography (PET) Scans

As a result of a recent Medicare national coverage decision (Publication 100-3, *Medicare National Coverage Determinations*, Section 220.6, effective January 28, 2005), CMS discontinued the HCPCS alphanumeric codes with initial letter "G" that had been used to report PET scans (Table 7 below), and activated the CPT codes listed below in Table 8 below for myocardial and nonmyocardial PET scans and concurrent PET/CT scans for anatomical localization.

These lists of codes, along with claims processing instructions, are provided in Change Request 3756 (Transmittal 514, Publication 100-04, found at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R514CP.pdf* on the CMS website. The corresponding MLN Matters article can be found at *http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM3756.pdf* on the CMS website.

Table 7: HCPCS Codes Not Valid for Medicare for Dates of Service on or after January 28, 2005

HCPCS Code	HCPCS Code	HCPCS Code	HCPCS Code
G0030	G0042	G0215	G0228
G0031	G0043	G0216	G0229

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

HCPCS Code	HCPCS Code	HCPCS Code	HCPCS Code
G0032	G0044	G0217	G0230
G0033	G0045	G0218	G0231
G0034	G0046	G0220	G0232
G0035	G0047	G0221	G0233
G0036	G0125	G0222	G0234
G0037	G0210	G0223	G0253
G0038	G0211	G0224	G0254
G0039	G0212	G0225	G0296
G0040	G0213	G0226	G0336
G0041	G0214	G0227	

Table 8: CPT Codes for Covered PET Scan Indications Effective for Dates of Service on or after January 28, 2005

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

Effective January 28, 2005, hospitals should report the CPT codes listed in Table 8 above for myocardial and nonmyocardial PET scans and concurrent PET/CT scans for anatomical localization delivered in the hospital outpatient setting.

In addition, in the CY 2006 OPPS final rule (70 FR 68581, *http://www.access.gpo.gov/su_docs/fedreg/a051110c.html*) CMS changed the

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

status indicator for CPT code 78609 (Brain imaging, PET; perfusion evaluation) from "S" (separately paid under the OPPS) to "E" (not paid under the OPPS) retroactive to January 28, 2005, as historically there has been and currently there remains no coverage for this service under the Medicare program.

Billing for Stereotactic Radiosurgery

Stereotactic radiosurgery (SRS) is a form of radiation therapy for treating abnormalities, functional disorders, and tumors of the brain, neck, and most recently has expanded to treating tumors of the spine, lung, pancreas, prostate, bone, and liver.

There are two basic methods in which SRS can be delivered to patients: *linear accelerator-based* treatment, and *multi-source photon-based* treatment (often referred to as Cobalt 60). Advances in technology have further distinguished linear accelerator-based SRS therapy into two types: *gantry-based systems* and *image-guided robotic SRS systems*. These two types of linear accelerator-based SRS therapies may be delivered in a complete session or in a fractionated course of therapy up to a maximum of five sessions.

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

Billing for Wound Care Services

Pursuant to a congressional mandate to pay for all therapy services under one prospective payment system, CMS created a therapy code list to identify and track outpatient therapy services paid under the Medicare Physician Fee Schedule (MFPS). (Balanced Budget Act of 1997, Pub. L. 105-33, Section 1834(k)(5))

CMS provides this list of therapy codes along with their respective designations in the *Medicare Claims Processing Manual* (Pub. 100-04, Chapter 5, Section 20, at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c05.pdf on the CMS website).

"Always" versus "Sometimes" Therapy

CMS defines an "always therapy" service as a service that must be performed by a qualified therapist under a certified therapy plan of care, and a "sometimes therapy" service as a service that may be performed by a non-therapist outside of a certified therapy plan of care.

Effective January 1, 2006, CMS is reclassifying CPT codes 97602, 97605, and 97606 as "sometimes therapy" services that may be appropriately provided either as therapy or non-therapy services, as well as maintaining our designation of CPT codes 97597 and 97598 as "sometimes therapy" services.

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

In order to pay hospitals accurately when delivering these "sometimes therapy" services independent of a therapy plan of care, CMS is establishing payment rates for CPT codes 97597, 97598, 97602, 97605, and 97606 under the OPPS when performed as non-therapy services in the hospital outpatient setting.

Table 9 below lists the APC assignments and status indicators for these codes when delivered independent of a therapy plan of care in a hospital outpatient setting.

Table 9: CPT Codes for Wound Care Services Paid under the OPPS Effective for Dates of Service on or after January 1, 2006

		CY 2005		CY 2006		
CPT Code	Descriptor	Therapy Designation	Status Indicator	Therapy Designation	APC	Status Indicator
97597	Selective debridement (less than or equal to 20 sq. cm.)	"Sometimes" therapy	A	"Sometimes" therapy	0012	T
97598	Selective debridement (greater than 20 sq. cm.)	"Sometimes" therapy	A	"Sometimes" therapy	0013	T
97602	Non-selective debridement	"Always" therapy	A	"Sometimes" therapy	0340	X
97605	Negative pressure wound therapy (less than or equal to 50 sq. cm.)	"Always" therapy	A	"Sometimes" therapy	0012	T
97606	Negative pressure wound therapy (greater than 50 sq. cm.)	"Always" therapy	A	"Sometimes" therapy	0013	T

To further clarify, hospitals will receive separate payment under the OPPS when they bill for wound care services described by CPT codes 97597, 97598, 97602, 97605, and 97606 that are furnished to hospital outpatients by non-therapists independent of a therapy plan of care.

In contrast, when such services are performed by a qualified therapist under an approved therapy plan of care, providers should attach an appropriate therapy modifier (that is, GP for physical therapy, GO for occupational therapy, and GN for speech-language pathology) and/or report their charges under a therapy revenue code (that is, 420, 430, or 440) to receive payment under the MPFS.

The OCE logic will either assign these services to the appropriate APC for payment under the OPPS if the services are non-therapy, or will direct Medicare

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

FIs to the MPFS established payment rates if the services are identified on hospital claims with a therapy modifier or therapy revenue code as therapy.

Billing for Therapeutic Apheresis

Services treating a variety of disorders by modifying or selectively removing agents from the blood and returning that blood to the patient include those described by the following CPT codes:

- 36515 (Therapeutic apheresis; with extracorporeal immunoadsorption and plasma reinfusion);
- 36516 (Therapeutic apheresis; with extracorporeal selective adsorption or selective filtration and plasma reinfusion); and
- 36522 (Photopheresis, extracorporeal).

In every case, hospitals should report the codes that most accurately describe the service that is furnished. When billing CPT code 36515 to report extracorporeal immunoadsorption treatment and plasma reinfusion with a protein A column for indications such as rheumatoid arthritis and idiopathic thrombocytopenic purpura, hospitals may:

- Include the charge for the protein A column in the procedure charge for CPT 36515; or
- May report the charge separately on a line with an appropriate supply revenue code.

Similarly, when billing CPT code 36516 to report extracorporeal selective adsorption or selective filtration and plasma reinfusion for indications such as familial hypercholesterolemia, supply charges may be included either in the procedure charge for CPT code 36516 or reported separately on a line with an appropriate supply revenue code.

Lastly, when billing CPT code 36522 to report extracorporeal photopheresis for indications such as cutaneous T cell lymphoma, hospital supply charges may be included in the charge for CPT code 36522 or billed separately on a line with an appropriate supply revenue code. In all cases, payments for the supplies are packaged into the OPPS payments for the apheresis service.

Billing for Allergy Testing

Providers have expressed confusion related to the reporting of units for allergy testing services described by CPT codes 95004 through 95078. Nine of these CPT codes instruct providers to specify the number of tests or use the singular word “test” in their descriptors, while five of these CPT codes do not contain such an instruction or do not contain “tests” or “testing” in their descriptors.

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

The lack of clarity related to the reporting of units has resulted in erroneous reporting of charges for multiple allergy tests under one unit (that is, "per visit") for the CPT codes that instruct providers to specify the number of tests.

Effective January 1, 2006, CMS is differentiating single allergy tests ("per test") from multiple allergy tests ("per visit") by assigning these services to two different APCs. CMS is assigning single allergy tests to newly established APC 0381 and maintaining multiple allergy tests in APC 0370.

Hospitals should report charges for the CPT codes that describe single allergy tests (or where CPT instructions direct providers to specify the number of tests) to reflect charges per test rather than per visit and bill the appropriate number of units of these CPT codes to describe all of the tests provided. Table 10 lists the assignment of CPT codes to APCs 0370 and 0381 for CY 2006.

Table 10: Assignment of CPT Codes to APC 0370 and APC 0381 for CY 2006

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

Corrections for the April 2006 Update

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

Table 11: HCPCS Deletions, Additions, and Reactivations

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

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Table 12: Short Descriptor Changes

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

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, whether it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

Note: For those home health agencies that may have some claims being held by their RHHI/FI due to the fact that there was no CBSA or "special wage index" in the RHHI/FI files, please be aware that CMS has instructed the RHHI/FI to update their files and process those claims.

Additional Information

For complete details, please see the official instruction issued to your FI/RHHI regarding this change. That instruction may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R804CP.pdf on the CMS website.

If you have any questions, please contact your FI/RHHI 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.

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.