Medicare Learning Network
MLN Matters®
CMS
Official Information Health Care Professionals Can Trust

NEWS FLASH	The ***Medicare Billing Information for Rural Providers, Suppliers*** which provides rural information pertaining to rural health facility types, coverage and payment policies, and rural provisions under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and the Deficit Reduction Act of 2005 is now available in downloadable format at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/RuralChart.pdf on the CMS website.

MLN Matters Number: MM5544 | Related Change Request (CR) #: 5544

Related CR Release Date: March 21, 2007 | Effective Date: April 1, 2007

Related CR Transmittal #: R1209CP | Implementation Date: April 2, 2007

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

Note: This article was updated on June 15, 2013, to reflect current Web addresses. All other information remains unchanged.

Provider Types Affected

Providers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for radiation therapy services provided to Medicare beneficiaries and paid under the OPPS.

Provider Action Needed

This article is based on Change Request (CR) 5544 which describes changes to, and billing instructions for, various payment policies implemented by the Centers for Medicare & Medicaid Services (CMS) in the April 2007 OPPS update.

Background

The April 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 CR5544.

CR 5544 describes the following changes to, and billing instructions for, payment policies implemented in the April 2007 OPPS update.

Additional Payment Information for Current Pass-Through Category C1820

Section 1833(t)(6)(D)(ii) of the Social Security Act 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).

For CY 2006, when creating new category C1820, (Generator, neurostimulator (implantable), with rechargeable battery and charging system), CMS determined that it could 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, which C1820 replaces in some cases. 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. In Transmittal 1139, Change Request (CR) 5438, issued December 22, 2006, CMS indicated that for CY 2007, the device offset portion for C1820, when billed with a procedure in APC 0222, is $8,668.94.

CMS has recently been informed that at least some rechargeable neurostimulators described by C1820 may also be used and therefore be billed with CPT code 61885, Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to single array, and CMS has changed the procedure to device edits accordingly. This change is effective January 1, 2006 and is implemented in the April 2007 OPPS OCE.

CPT code 61885 maps to APC 0039, which has a CY 2007offset percent of 78.85 percent. (71 FR 68077) Based on this percent, the device offset to be subtracted from the payment for C1820, when it is billed with CPT code 61885, is $9,081.94. Note that the offset amount from the APC payment is wage adjusted before it is subtracted from the device cost.

Payment for Certain Laboratory Services

Effective for services furnished on or after the date listed in the table below, the unlisted laboratory CPT codes in the table are assigned to a status indicator of “A.” The clinical lab fee schedule does not provide a payment amount for these unlisted laboratory codes, since the Medicare carrier prices them. Therefore, your FI must review the narrative description of the test submitted by the hospital to determine if a specific HCPCS code is available to describe the laboratory test. If a specific HCPCS code is available, this code should be reported by the hospital for the laboratory test, rather than an unlisted laboratory CPT code. If there is no appropriate specific code, the FI will contact the carrier in your jurisdiction to obtain

an appropriate payment amount for services reported with these laboratory CPT codes. If that carrier cannot provide a payment amount for the services, then to obtain a payment rate, the FI must contact the carrier in the jurisdiction of the reference laboratory that performed the test. If neither carrier has a payment amount for the test and the FI determines that the service is covered, the FI will determine the payment amount. (Note that FIs will not search their files for to adjust previously processed claims, but will adjust claims affected by this issue if you bring those claims to your FI's attention.) FIs will follow this same procedure to develop payment amounts for such laboratory tests when it is paying a non-OPPS claim for an unlisted laboratory CPT code.

Beneficiary co-insurance and deductible are not applied to unlisted clinical laboratory services.

HCPCS Code	Long Descriptor	Effective Date
81099	Unlisted urinalysis procedure	08/01/00
84999	Unlisted chemistry procedure	08/01/00
85999	Unlisted hematology and coagulation procedure	08/01/00
86849	Unlisted immunology procedure	08/01/00
87999	Unlisted microbiology procedure	08/01/00

Clarification to Billing and Payment for IMRT Planning

Payment for services identified by the CPT codes in the following table is included in the Ambulatory Payment Classification (APC) payment for Intensity Modulated Radiation Therapy (IMRT) planning when these services are performed as part of developing an IMRT plan that is reported using CPT code 77301:

CPT Code(s)	Descriptor(s)
77280-77295	Simulation for Brachytherapy
77305-77321	Tele-therapy Isodose Plan
77331	Special Dosimetry
77336	Continuing Medical Radiation Physics Consultation
77370	Special Medical Radiation Physics Consultation

When these services are performed as part of developing an IMRT plan, these CPT codes should not be billed in addition to CPT code 77301 for IMRT planning.

However, payment for IMRT planning does not include payment for services described by the following CPT codes:

CPT Code(s)	Descriptor(s)
77332 - 77334	Treatment Devices, Designs and Construction

When provided, the services identified by CPT Codes 77332-77334 should be billed in addition to the IMRT planning code (CPT Code 77301).

Clarification to Payment policy for 77435, Stereotactic Body Radiation Therapy, Treatment Management, per Treatment Course, to One or More Lesions, Including Image Guidance, Entire Course not to Exceed 5 Fractions.

CR5544 clarifies payment policy for stereotactic radiosurgery (SRS) service described by CPT code 77435. In CR 5438, issued December 22, 2006, CMS inadvertently listed 77435 with status indicator of "B." However, the January 2007 update of the OPPS Addendum B posted on the CMS website and the January 2007 OPPS OCE contained the correct status indicator of "N."

Payment Status Indicators for "Special" Packaged CPT Codes: 36540, Collection of Blood Specimen from a Completely Implantable Venous Access Device; and 96523, Irrigation of Implanted Venous Access Device for Drug Delivery Systems

"Special" packaged CPT codes 36540 and 96523 were erroneously listed with status indicator "S" in CR 5438, issued on December 22, 2006, and in the CY 2007 OPPS final rule. Although this error does not affect payment rates for the services described by these CPT codes, CMS is clarifying that the correct status indicator assigned by the OCE for separate payment is "X," as assigned to APC 624, Minor Vascular Access Device Procedures, in the January 2007 OPPS update of Addendum A.

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.

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

In the CY 2007 OPPS final rule, CMS 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, CMS will incorporate changes to the payment rates in the April 2007 release of the OPPS PRICER. The updated payment rates effective April 1, 2007, will be included in the April 2007 update of the OPPS Addendum A and Addendum B, which will be posted on the CMS website at the end of March.

Updated Payment Rates for Certain Drugs and Biologicals Effective July 1, 2006 through September 30, 2006

The payment rates for the drugs and biologicals listed below were incorrect in the January 2007 OPPS PRICER. The corrected payment rates will be installed in the April 2007 OPPS PRICER effective for services furnished on July 1, 2006, through September 30, 2006.

HCPCS	APC	Short Description	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
90371	1630	Hep b ig, im	$118.29	$23.66
J2430	0730	Pamidronate disodium /30 MG	$36.17	$7.23
J7340	1632	Metabolic active D/E tissue	$25.66	$5.13
J7344	9156	Nonmetabolic active tissue	$93.06	$18.61
J9015	0807	Aldesleukin/single use vial	$723.38	$144.68

Updated Payment Rates for Certain Drugs and Biologicals Effective October 1, 2006 through December 31, 2006

The payment rates for the drugs and biologicals listed below were incorrect in the January 2007 OPPS PRICER. The corrected payment rates will be installed in the April 2007 OPPS PRICER effective for services furnished on October 1, 2006, through December 31, 2006.

HCPCS	APC	Short Description	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
90371	1630	Hep b ig, im	$113.27	$22.65
J2430	0730	Pamidronate disodium /30 MG	$35.46	$7.09
J7340	1632	Metabolic active D/E tissue	$21.37	$4.27
J7344	9156	Nonmetabolic active tissue	$89.31	$17.86

HCPCS	APC	Short Description	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
90716	9142	Chicken pox vaccine, sc	$72.28	$14.46
J0637	9019	Caspofungin acetate	$32.22	$6.44
J9265	0863	Paclitaxel injection	$15.11	$3.02

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.

The full descriptors for the Level II HCPCS codes can be found in the latest code books or from the latest Level II HCPCS file, which is available for downloading from http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/index.html on the CMS website.

Providers are reminded to check HCPCS descriptors for any changes to the units per HCPCS when HCPCS definitions or codes are changed.

Modification of Blood Deductible Edits

CMS notified your Medicare contractor (FI, MAC, or RHHI) on January 26, 2007 that blood deductible is acceptable for ALL 38x revenue codes, instead of only revenue codes 380-382.

Changes to Device Edits in the April 2007 OCE

CMS has made the following changes to the device edits in the April 2007 OCE. Providers who have claims that were returned for failure to pass the device edits that were in place before April 1, 2007 should review the changes to determine if the claims will now pass the edits. If the provider believes that the changes made

in the April 2007 OCE enable the claims to satisfy (and thus pass) the edits, the provider should submit the claims for payment.

Device to Procedure Edit Changes Being Implemented in the April 2007 OCE; Effective for Services Furnished on or After January 1, 2007

C1820 (Generator, neuro rechg bat sys) is now allowed with 61885 (Insrt/redo neurostim 1 array)

C1898 (Lead, pmkr, other than trans) is now allowed with G0300 (Insert reposit lead dual+gen)

C1779 (Lead, pmkr, transvenous VDD) is now allowed with G0300 (Insert reposit lead dual+gen)

Procedure to Device Edit Changes Being Implemented in the April 2007 OCE with Effective Dates as Shown:

93651 (Ablate heart dysrhythm focus) is now allowed with C2630 (Cath EP, Cool tip); effective 1/1/07

33206 (Insertion of heart pacemaker) is now allowed with C2621 (Pmkr, single, non rate-resp); effective 10/01/05

33212 (Insertion of pulse generator) is now allowed with C2621 (Pmkr, single, non rate-resp); effective 04/01/05

61885 (Insrt/redo neurostim 1 array) is now allowed with C1820 (Generator, neuro rechg bat sys); effective 1/01/06

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. FIs determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, FIs determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

Additional Information

The official instruction, CR5544, issued to your Medicare FI, RHHI, and A/B MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1209CP.pdf on the CMS website.

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